S. HRG. 99-778

HIGH RISK OCCUPATIONAL DISEASE NOTIFICATION AND PREVENTION ACT OF 1986

HEARING

BEFORE THE

SUBCOMMITTEE ON LABOR

OF THE

COMMITTEE ON LABOR AND HUMAN RESOURCES UNITED STATES SENATE

NINETY-NINTH CONGRESS

SECOND SESSION

ON

S. 2050

TO NOTIFY WORKERS WHO ARE AT RISK OF OCCUPATIONAL DISEASE IN ORDER TO ESTABLISH A SYSTEM FOR IDENTIFYING AND PREVENTING ILLNESS AND DEATH OF SUCH WORKERS, AND FOR OTHER PURPOSES

MAY 15, 1986

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HIGH RISK OCCUPATIONAL DISEASE NOTIFICATION AND PREVENTION ACT OF 1986

THURSDAY, MAY 15, 1986

U.S. SENATE,
SUBCOMMITTEE ON LABOR,
COMMITTEE ON LABOR AND HUMAN RESOURCES,
Washington, DC.

The subcommittee convened, pursuant to notice, at 9:04 a.m., in room SD-430, Dirksen Senate Office Building, Senator Don Nickles (chairman of the subcommittee) presiding.

Present: Senators Nickles, Kennedy, and Metzenbaum.

OPENING STATEMENT OF SENATOR NICKLES

Senator NICKLES. Good morning. Today's hearing will examine S. 2050, introduced by Senator Metzenbaum, to notify workers who are at risk of occupational disease in order to establish a system for identifying and preventing illness and death of such workers and for other purposes.

Certainly, no one can oppose the objectives of such a bill. Prevention of illness and death of workers is and should be of utmost concern to everyone in Government, business, and also organized labor.

In fact, I am pleased that the Occupational Safety and Health Administration promulgated its Health Communication Standard and that it becomes fully effective in the manufacturing sector on May 25, just 10 days from today. It is anticipated that this new standard, coupled with OSHA's Access to Employee Exposure and Medical Records Rule, promulgated in August 1980, will make tremendous progress in notifying workers of any exposures to hazardous substances.

The National Institute for Occupational Safety and Health estimated in 1972 that there are 575,000 hazardous chemical products in commerce today. I applaud OSHA for the steps taken to mandate that employers provide their employees with both information and training on hazardous chemicals in their work areas, both at the time of their initial assignment and whenever a new hazard is introduced into the work area. This notification is at the employer's expense, rather than being charged to the Federal Treasury.

I know some think that OSHA has not gone far enough in its efforts, or that they find fault with some of the methods that are used. That is why we are holding today's hearing.

As initially stated, we will examine Senator Metzenbaum's alternative approach to the efforts already underway or to be implemented later this month.

We have several outstanding panelists. We also have a lot of conflicts going on in the Senate today. I know that Senator Metzenbaum and I are both sitting on another committee that is having a markup on important legislation. It will probably be necessary for either of us to be breaking off at different times to vote or have input on that legislation.

In addition, it is necessary for me to testify on different legislation pending before the House of Representatives at around 10:20, and I will have to leave for that.

I will ask all of our panelists to keep your oral remarks within 5 minutes to allow Senators Metzenbaum, Kennedy, and others the opportunity for some input and questions. Your entire statements will be included in the record in full.

Senator Kennedy, do you have an opening comment?

Senator KENNEDY. I do. I would just like to ask that it appear in the record, Mr. Chairman.

Senator NICKLES. Certainly.

OPENING STATEMENT OF SENATOR KENNEDY

Senator KENNEDY. I want to express my appreciation for having these hearings on a matter of what I consider to be of very significant importance. I do not think that there is any question today that there are millions of Americans who are not really effectively covered by the right to know provisions which are in existence as law, and as we are, obviously, all of us concerned about the problems in terms of overburdening the courts, and the increased premiums on liability insurance, we are also mindful that there are millions of Americans who are at risk and whose health is being damaged today.

I think that the right to know concept is one which is, and should be firmly engrained in our whole sense of protecting the lives and the well-being of workers in our society and consumers in our society and other areas as well. And it is my own belief that this legislation moves us very significantly in that area to provide degrees of protection which are not being achieved under existing statutes today, under NIOSH and OSHA, and I think we will hear later about what the impact will be if we do not address this particular issue, what is happening across our country today.

So I want to thank you, Mr. Chairman. We know it is a complex issue. I take heart that the House of Representatives has been moving. They have had very important hearings on this subject, have been dealing with many of the issues that we will hear about, and from those who are opponents to this legislation. But I do think we have an important responsibility to have these hearings, to be able to present to our colleagues the magnitude of the problem, what this legislation is attempting to do, and I would be very hopeful that we could at least move this legislation so that we can provide that degree of knowledge to the American workers, which I quite frankly believe they are entitled to.

I thank the Chair.

Senator NICKLES. Senator Kennedy, thank you very much.

The principal sponsor of S. 2050 is Senator Metzenbaum. This hearing is at Senator Metzenbaum's request, and we are glad that you could join us.

At this time we insert the opening statement of Senator Metzenbaum and a statement by Senator Matsunaga in the record.

[The statements of Senators Metzenbaum and Matsunaga follow:]

OPENING STATEMENT BY SENATOR HOWARD M. METZENBAUM

Senator METZENBAUM. Today's hearing addresses S. 2050, the High Risk Occupational Disease Notification and Prevention Act of 1986. This bill, which Senator Stafford and I introduced, calls for a reasonable federal response to an exploding national problem: occupationally related disease.

Millions of American workers have been or continue to be exposed to toxic chemicals, wastes, fumes, dusts and industrial processes. Such exposures substantially increase the risk that those exposed will suffer disabling or terminal disease conditions. The asbestos tragedy—in which thousands have died and thousands more will die—has awakened the American public to the magnitude of the problem.

But asbestos is just the tip of the iceberg. Each year, some 100,000 workers die and 340,000 more are disabled from occupational diseases. The National Institute for Occupational Safety and Health has estimated that 880,000 workers face full or part-time exposure to carcinogens regulated by OSHA; that 25 percent of the workforce is exposed to OSHA-regulated hazards on the job; that 40 to 50 million Americans have been exposed to one or more of these hazards during their work lives.

In short, the lives of millions of American workers go on the line every day they punch a time clock. These men and women have an absolute right to know what risks they are taking and how to cope with those risks. To do any less is to participate in a conspiracy of silence which unnecessarily jeopardizes their lives.

Today we will hear from four victims of the silent conspiracy. Theirs is a story of devastating human costs, costs that could have been avoided through a notification and prevention program. Our responsibility to them, and to their millions of fellow employees, is to enact the bill before us.

Since Congress passed the Occupational Safety and Health Act of 1970, the federal government has made progress in regulating employee exposure to hazardous substances in the workplace. The efforts of OSHA, the EPA and NIOSH have enabled us to learn more about hazardous occupational exposures, and begin to limit these exposures through regulation.

Still, regulating exposures is not enough. American industry is not going to stop producing hazardous chemicals and other substances, nor should it do so. Often, the substances are essential—either as elements or as byproducts—to the jobs performed or the goods and services consumed by the American public.

What, then, can we do? Occupational disease is not going to disappear. One thing we can, and should, do is undertake a serious national effort to promote the prevention and early detection of occupational disease. By doing so, we will reap three enormous benefits. First, for thousands of workers and their families, we will avoid the misery of death or disabling disease. Second, through prevention or successful treatment, we will save millions of dollars in federal and private health care costs. Finally, we will serve the ends of simple justice.

S. 2050 seeks to accomplish these goals through a low-cost system for identifying, notifying and monitoring targeted worker populations. Identification and notification, based on existing medical and scientific data, will be carried out by a professional panel operating under the direction of the secretary of HHS. Workers who are identified and notified will be advised on how to initiate appropriate medical monitoring. Regional health centers will provide training and emergency backup assistance.

The need for a notification and prevention program has never been more apparent. A new study published last week in the New England Journal of Medicine found that three decades of medical research aimed primarily at cancer treatment have failed to stop the rising rate of death from cancer among Americans. One of its central conclusions is that as a nation we must spend more money on cancer prevention, including showing the American people how changes in environmental factors can substantially reduce cancer risks. Anyone who has a passing familiarity with the enormous financial costs of health care coverage would reach the same conclusion. Indeed, at a recent health insurance conference on wellness in the workplace, an industry representative declared that the new challenge is to develop

"proactive products" aimed at preventing health breakdowns rather than simply reacting to the expense of illness after it occurs.

This morning, we will be listening to testimony from opponents as well as supporters of S. 2050. I welcome both sides to the debate, because I believe we need constructive criticism in order to fashion the best law possible, one that is fair to employers as well as workers, and one that can be enforced effectively and efficiently by the administration. But one thing is clear: it is too late in the day to deny the need for such a law. The working men and women of this country deserve this kind of national preventive health program. I intend to do everything I can to see that they get it.

STATEMENT BY THE HONORABLE SPARK M. MATSUNAGA
Subcommittee on Labor
SD-430 Dirksen Senate Office Building
Thursday, May 15, 1986

Mr. Chairman, with your permission I wish as a cosponsor of S. 2050 to express some of my thoughts on notifying workers who risk contracting occupational disease at the worksite identifying their illness, and preventing early death.

Hawaii has had its share of experiences with the ill effects of occupational diseases, specifically in connection with asbestos. According to research being conducted by the University of Southern California, one in every five active and retired Pearl Harbor shipyard workers has shown the effects of asbestosis. These findings are in line with the results of tests made on shipyard workers from other parts of the country. Of more than 900 Pearl Harbor workers tested last July and November, 20% were found to be susceptible to asbestos disease.

It was further discovered that the ill effects of asbestos did not end with the workers. Family members of these shipyard workers were also placed under risk, since it is theorized that workers take home asbestos dust on their bodies and clothing and subsequently expose their spouses and children to the hazardous material.

I have received many letters from constituents who were exposed to the dust and who subsequently contracted the disease. As in many known cases, the effects of the exposure are frequently not immediately apparent, due to long latency periods. Based on the testimonies of witnesses today, I hope that this subcommittee will be able to provide some means by which workers will no longer be unknowingly exposed to toxic substances, fumes, or dust that could result in illness or death. In doing so, we will not only be providing for the health and welfare of the workers themselves, but also of that of their families, all of whom may be innocent victims of an intolerable situation.

It was on behalf of those Pearl Harbor victims and others like themselves, as well as in the interest of future generations of workers and their families, that I agreed to cosponsor S. 2050. I will be listening with great interest to the testimonies of the witnesses this morning in the hope of finding some solution to a serious life-or-death problem faced by many of our unprotected workers and their families. Thank you.

# # #

Senator NICKLES. Our first panelists representing the administration are Robert Willmore, Deputy Assistant Attorney General, Department of Justice; Patrick Tyson, who is Acting Assistant Secretary for OSHA, for the Department of Labor; and James Melius, M.D., Director, Division of Surveillance, Hazard Evaluation and Field Studies for NIOSH, Department of Health and Human Services.

Mr. Tyson.

Mr. TYSON. Mr. Chairman, I need to introduce one other individual up here. Craig Barrington, who is the Deputy Assistant Secretary for Employment Standards Administration in the Department of Labor, will also be here.

Senator NICKLES. To our panelists, we thank you very much.

Mr. Willmore.

STATEMENT OF ROBERT L. WILLMORE, DEPUTY ASSISTANT ATTORNEY GENERAL, CIVIL DIVISION, DEPARTMENT OF JUSTICE, WASHINGTON, DC; PATRICK R. TYSON, ACTING ASSISTANT SECRETARY OF LABOR FOR OSHA, DEPARTMENT OF LABOR, WASHINGTON, DC, ACCOMPANIED BY CRAIG BARRINGTON, DEPUTY ASSISTANT SECRETARY FOR EMPLOYMENT STANDARDS ADMINISTRATION; AND DR. JAMES MELIUS, DIRECTOR, DIVISION OF SURVEILLANCE, HAZARD EVALUATION AND FIELD STUDIES, NIOSH, CINCINNATI, OH, ACCOMPANIED BY PHILIP BIERBAUM, DEPUTY DIRECTOR, DSHEFS

Mr. WILLMORE. Thank you, Mr. Chairman.

I appreciate the opportunity to appear on behalf of the Department of Justice on S. 2050, and I will summarize my statement.

The Department opposes enactment of the bill. In addition to the reasons contained in the statements of the Department of Labor and the Department of Health and Human Services, with which we are in full accord, there are three specific concerns that we discuss in our statement.

The first concern is that we do not believe S. 2050 adequately deals with the liability concerns of the United States and its employees. Those concerns were discussed at length in our letter to and subsequent testimony before Chairman Gaydos in the House. In the letter which is attached to my testimony, we indicate that the liability for the United States under this particular scheme could be staggering, as could be the liability for Federal employees.

The reason for this is very simple. I will not go into it in any depth. This scheme is very different from most, if not all other notice requirements existing under Federal law. This proposal places the onus on the Federal Government, rather than on the employer or the supplier of the product or the service, to provide the notice.

Thus, if something is inadequate with the notice, in that either the wrong people are informed, or they are informed of facts that subsequently are found to be incorrect or inadequate, the United States will most likely bear the liability. This liability, in fact, could be very, very high.

Our second concern which I will discuss is our belief that this bill will result in substantial litigation against private parties, particu-

larly against, the producers of the products that are the subject of the notices. We believe much of the litigation under the scheme set out in this bill will be without merit.

Finally, there is a provision in the bill that we see as a potentially serious and unjustified interference with the operation of State worker compensation systems.

If I may just address the first concern very briefly, S. 2050 is different from H.R. 1309 in that it does contain a provision, section 5(h), which attempts to create some protection for the Government and for Government employees from tort litigation.

We have carefully analyzed that section, and we are persuaded that it is inadequate for the reasons discussed in our statement. It is limited to the Department of Health and Human Services and to employees of HHS. Not all of the Federal agencies and all of the Federal employees are protected. For instance, employees of the Department of Labor, the EPA, or other departments, would not be protected, and therefore, the United States, itself, would not be protected in that context.

The section does not deal with the liability of Federal employees under constitutional lawsuits—there have been over 12,000 such cases in the last 15 years. Further, it does not deal with the growing area of liability of Federal employees under State common law. Unfortunately, Federal employee liability under state common law is becoming an increasing problem, particularly in recent years, as the absolute immunity established by the Supreme Court in *Barr* v. *Matteo* for Federal employees has been reduced by the appellate courts.

I would add also in passing that to the extent that section 5(h) attempts to protect employers and governments who are certified under the section to help implement the provisions of the section, that immunity is in our opinion largely illusory, since most of the litigation that will be brought against these employers and governments will be brought under State common law.

In other words, I think it will be very, very difficult to certify anybody given the liability concerns, because there really is no protection for these entities.

We would also note that, putting aside the question of the liability of the United States and its employees under this statute, the statute will create significant and substantial litigation in the private sector, most likely against the producers of the products that are the subject of the notices. We believe that a great deal of this litigation will be without merit, because of the trigger mechanism within the bill, that essentially uses an arbitrary and, in many instances, indefensible method for identifying which products will be the subject of such notices. While we believe that some may welcome such increased litigation, we would simply note for the benefit of the subcommittee that the country currently is, as I think every member of the Congress understands, mired in a tort litigation and an insurance availability crisis of very substantial proportions.

This bill will almost certainly exacerbate that crisis. That crisis is particularly troubling in the area of toxic torts which, after all, is what this bill apparently is aimed at dealing with. It is very difficult at this time for any producer of a toxic substance or potential-

ly toxic substance to obtain liability insurance. In many areas, such insurance is simply unavailable. This scheme will greatly exacerbate their problems. Many companies will not be able to obtain insurance. Whether they will continue in operation, whether they will continue to offer jobs, is a matter of speculation; we simply do not know, but we believe that is something that the subcommittee should take into account. And as I noted, much of this litigation, we believe, will be without merit.

Finally, section 9(d) of the bill represents, for the reasons discussed in my statement—and I would like to add that it is a rather confusingly drafted subsection, and we are not sure what it means—but if it means what it seems to mean on its face, then it represents a very significant and very troubling precedent of Federal interference in the operation of State worker compensation systems, and we would strongly oppose that.

Thank you very much.

Senator NICKLES. Mr. Willmore, thank you very much for your comments.

[The prepared statement of Mr. Willmore and responses to questions submitted by Senator Metzenbaum follow:]

Department of Justice

STATEMENT

OF

ROBERT L. WILLMORE
DEPUTY ASSISTANT ATTORNEY GENERAL
CIVIL DIVISION

BEFORE

THE

SUBCOMMITTEE ON LABOR
COMMITTEE ON LABOR AND HUMAN RESOURCES
UNITED STATES SENATE

CONCERNING

S. 2050

ON

MAY 15, 1986

I am pleased to appear before the Labor Subcommittee today to present the views of the Department of Justice on S. 2050, a bill "to notify workers who are at risk of occupational disease in order to establish a system for identifying and preventing illness and death of such workers, and for other purposes."

The Department of Justice opposes enactment of S. 2050 for several reasons. First, it is by no means clear that Section 5(h) of the bill adequately protects the public fisc from lawsuits against the United States seeking damages for injuries allegedly arising from the implementation of the statutory scheme. As the Department has noted with regard to H.R. 1309, a similar measure introduced in the House of Representatives, the potential liability of the United States under this legislation could be staggering.

Second the bill almost certainly will result in substantial litigation that, while in many instances largely without merit, will impose significant costs upon both consumers and workers.

Finally, the bill potentially represents an unacceptable intrusion of the Federal government into state workers' compensation systems.

In a letter dated November 15, 1985, from Acting Assistant Attorney General Phillip Brady to Chairman Joseph Gaydos, the Department expressed its serious concerns regarding the potential liability of the United States and its employees should H.R. 1309 be enacted. A copy of that letter is attached to this testimony. As can be noted from the letter, since S. 2050 is similar in many respects to H.R. 1309, these same concerns apply to S. 2050.

S. 2050, however, unlike H.R. 1309, contains a provision, Section 5(h), providing some protection for the United States from such suits. While the inclusion of the provision is a clear improvement of the legislation, it nevertheless only partially addresses the Department's concerns.

For instance, as for the liability of the United States, Section 5(h) only applies to the Department of Health and Human Services, and only applies to activities conducted under Section 5. Thus, to the extent any other department or agency (such as the Department of Labor or the Environmental Protection Agency) of the United States provides support or advice to the Department of Health and Human Services, it appears to be unprotected (except perhaps in its capacity as an employer) under the Section. As important is the limitation of Section 5(h) to liability arising out of any act or omission performed pursuant to Section 5. There are a number of other sections in the bill that could be the basis of such suits against the United States. In

particular, Section 4, which sets out the responsibilities of the Risk Assessment Board, could be a significant source of "duties" which a plaintiff could assert were breached and which, therefore, might serve as the basis for public liability.

In addition, the protection in Section 5(h) for "any employer or government acting pursuant to subsection (g)" is largely illusory since it applies only to a suit for monetary damages under Federal law. Virtually all such litigation against private persons and state and local officials would take place under state law (the major exception being claims against public officials brought under 42 U.S.C. § 1983). Thus, an employer or a government (with the exception of Federal agencies) "certified" under Section 5(g) essentially would be unprotected by this legislation.

It also is unclear how much, if any, protection the provision provides to Federal employees sued in their personal capacities in claims predicated on the Constitution -- that is, what are commonly known as Bivens claims. There have been over 12,000 such claims against Federal employees since the Supreme Court's 1971 decision in Bivens v. Six Unknown Named Agents of the Federal Bureau of Narcotics, 403 U.S. 388, and they have become an all too common vehicle for harassment and intimidation of Federal employees. It is, of course, possible that the courts would read the term "Federal law" in Section 5(h) to include

Bivens claims; but, it also is quite possible that the courts would not.

Equally troubling is the potential liability of Federal employees under state common law. While it has been the Department's position that the 1959 decision of the Supreme Court in Barr v. Matteo, 360 U.S. 564, provides Federal employees with absolute immunity from such liability, there have been recent judicial inroads into the immunity which attempt to restrict it to "discretionary" or "policy" activities. See, e.g., Lojuk v. Johnson, 770 F.2d 619 (7th Cir. 1985); Johns v. Pettibone Corp., 769 F. 2d 724 (11th Cir. 1985). Of course, state common law claims against Federal employees are not addressed by Section 5(h). It should be noted in this regard that to the extent that authority exists or is created to indemnify such employees their liability under the Constitution or state common law could be passed back to the taxpayer.

In sum, Section 5(h) provides some protection for the United States, little to no real protection for employers or governments "certified" under Section 5(g), and very limited protection to Federal employees sued in their personal capacities.

A second major concern of the Department with regard to this legislation is that it almost certainly will spawn a great deal of litigation, much of it without real merit. S. 2050

requires notification of every worker found to be part of a "population at risk." An exposed population is "at risk" when a disease associated with a particular substance occurs at a rate thirty percent greater than in a comparable non-exposed population. This is an essentially arbitrary standard that in many instances will result in the notification of thousands or tens of thousands of workers where there in fact may be no significant danger. This is because for many substances -- perhaps even the majority of substances which would be the subject of such notifications -- the number of individuals with a particular disease may be so small that a thirty percent incidence difference between two populations may not be statistically meaningful. Simply put, the legislation disregards sophisticated and credible statistical methodology for determining when a particular difference in disease incidence is meaningful in favor of an arbitrary and unscientific standard that can easily mislead.

Putting aside the obvious question of whether the government should be notifying workers that they are "at risk" of contracting a potentially devastating disease when in fact no such increased risk may exist (or that risk may be extremely small), such notifications are almost certain to result in substantial litigation by workers against the manufacturers of the substances that are the subject of the notification. Some of this litigation will involve workers who actually have the

disease. But, very likely, much if not most of the litigation will involve workers who have other diseases (perhaps other forms of cancer than that associated with the exposure), or workers who sue for fear of contracting the disease (fear perhaps generated by the notification), or workers who sue for the increased likelihood of contracting the disease.

While some would welcome such increased litigation, the Subcommittee should take note that the United States currently is mired in a tort liability crisis that threatens the financial viability of many industries and is causing the elimination of products that are useful to and desired by the public but which generate too great a litigation risk. This problem is particularly serious in all areas which potentially involve toxic tort litigation. For example, many companies that generate or transport hazardous wastes or that operate disposal sites are finding it almost impossible in the current legal climate to obtain liability insurance at any price. The problem is now so serious that both the House and Senate Superfund reauthorization bills contain provisions providing authority for the indemnification of contractors cleaning up hazardous waste sites -- just to ensure that the sites that the government has selected for clean up can in fact be cleaned up.

Legislation such as S. 2050 will almost certainly exacerbate and extend the effects of the current tort liability crisis to

other parts of the economy. This is particularly troublesome in those situations where the notified workers are mistakenly led to believe that they are "at risk" when no such risk (or an extremely small risk) in fact exists. While the manufacturers may prevail in the personal injury litigation that will undoubtedly ensue, the high defense and other costs that such litigation entails will be passed on through higher prices for consumers, a loss in jobs, and a transfer of money away from productive activities into the pockets of lawyers.

Finally, S. 2050 contains a provision which may represent a significant incursion of the Federal government into state workers' compensation systems. Section 9(d) provides that any treatment provided by a health care financing system for a notified disease "may constitute an insurance subrogation claim against a workers' compensation program or insurance carrier."

It is unclear exactly what this provision is designed to accomplish, but it may be read by some courts to require the workers' compensation carrier to reimburse the health care financing system for any expenses of providing such treatment. If the section in fact is read this way, it could be construed to impute causation, at least to the extent of requiring the workers' compensation system to pay the health care costs. Thus, for diseases that are the subject of a notification pursuant to the legislation, the workers' compensation system under such an

interpretation could be required to pay the health care costs even if causation is not established under the procedures and standards used by the system. It may be that this is not the intent of the section, though it is unclear what the section is intended to accomplish and how it will be interpreted by the courts.

To the extent Section 9(d) is read in this way, however, there is no justification for such a Federal intrusion into the operation of state workers' compensation systems. Moreover, such an intrusion would represent an unacceptable precedent in setting Federal standards for state workers' compensation systems.

I appreciate the opportunity to present the views of the Department of Justice on this legislation. I will be pleased to answer any questions you may have.

U.S. Department of Justice

Office of Legislative and Intergovernmental Affairs

Office of the Assistant Attorney General

Washington, D.C. 20530

NOV 15 1985

The Honorable Joseph M. Gaydos
Chairman
Subcommittee on Health and Safety
Committee on Education and Labor
House of Representatives
Washington, D.C. 20515

Dear Chairman Gaydos:

The purpose of this letter is to present the views of the Department of Justice on H.R. 1309, a bill "to establish a system for identifying, notifying, and preventing illness and death among workers who are at increased or high risk of occupational disease and for other purposes." The Department of Health and Human Services reported to you on this bill by letter dated November 14, 1985. This letter supplements the letter of the Department of Health and Human Services by providing additional advice on the effect of Section 5 ("Employee Notification and Counseling") of H.R. 1309.

Section 5 would require the Secretary of HHS to notify each individual of a category of employees determined to be at increased risk of occupational disease of, inter alia, the "nature and degree of risk," the "disease or diseases" associated with the exposure, any known "latency periods," the "size, nature, and composition of the population at risk," and to provide "counseling information," including information on the appropriate type of "medical monitoring" and the appropriate "personal" medical monitoring program.

While we firmly agree with the views of the Department of Health and Human Services, we would raise the additional serious concern that an important effect of this legislation would be to impose potentially enormous tort liability upon the United States. Because such tort liability could well amount to hundreds of millions, if not billions of dollars, and add thousands of new lawsuits to the already burgeoning tort dockets of the federal courts, the Department of Justice strongly opposes enactment of H.R. 1309.

Unlike other state and federal statutes, which impose duties to provide a safe work place directly on persons responsible for employee working conditions at the work place, Section 5 would require the federal government to warn employees. Under the Federal Tort Claims Act, 28 U.S.C. §§ 1346(b), 2671-2680, the United States may be liable in essentially the same manner as a private person may be liable for a tort, subject to the specific exceptions and exclusions set forth in the Federal Tort Claims Act. The undertakings required by Section 5 could be the predicate of a duty to warn employees and result in potential liability by extension of common law principles of tort liability. See, e.g. §323 of the Restatement of Torts (3d). Thus, the United States may be liable for the consequences of its undertaking, however gratuitous, to provide a warning, imposed by the bill, even though it otherwise would have no potential liability.

It seems clear that the contents of the notification set forth in Section 5(b) have a very real potential for the imposition of tort liability on the United States. Terminological and semantic disputes regarding whether the "nature and degree of risk" is adequately described in a notification or whether the notification is inadequate in the retrospective view of a court faced with a suit by a person suffering from an occupational disease are grist for the mill of torts litigation.

Similarly, the bill's requirement that the "disease or diseases" be included in a notification will inevitably give rise to litigation over whether another disease or diseases should have been included in the notification. For instance, after there was public notification that one illness was associated with administration of the swine flu vaccine under the Swine Flu Immunization Program of 1976, many claims and suits were filed alleging that other maladies were likewise associated with the Swine Flu Program. Most of the suits filed subsequently, pursuant to the terms of the Swine Flu Program of 1976, involved illnesses other than the one illness which the Department of Health and Human Services stated was associated with the swine flu vaccine.

Likewise, Section 5(b)(4) of the bill requires that "latency periods" be specified. Litigation is certain to be brought by persons whose injuries are not within the terms specified in the notification alleging that the information provided is insufficiently precise or complete, or that the data upon which it is based is incomplete or inaccurate.

Great potential for protracted and costly litigation also flows from the requirement that the "size, nature, and composition of the population at risk" be included in a notification since individuals not within the defined group will challenge the notification as inadequate in that it does not include them within the targeted "population at risk." Retrospective litigation over what information should have been provided in a

notification could well lead to tort recoveries against the United States for individuals who were on or beyond the periphery of the groups targeted in a notice. Claims for mental anguish, loss of employment due to inaccurate notices, as well as claims based upon theories such as those outlined above, could likewise be expected. In addition, the problems of determining causation would be significant. In many instances it could be highly difficult to trace an individual's current condition to his or her work status -- particularly when that condition may be more directly attributable to other factors, including that individual's lifestyle.

The Department, of course, would vigorously contest such tort suits against the United States. However, the large number of such lawsuits would require substantial resources to defend. Even one personal injury award can result in a judgment for several million dollars predicated upon pain and suffering and pecuniary losses due to injuries (such as cancers) that might be the subject of notification. Given the broad and vague terminology of the bill and the vagaries of the litigation process, it is essential that the Congress carefully consider the provision's obvious potential for tort litigation.

Finally, it should be all too obvious that employees who believe themselves to have been exposed to a toxic substance, will find the United States, with its "deep pocket," a far more attractive target than their employers who, under current interpretations of the law, in most instances will be immune from suit because of the exclusivity of remedies under state workers' compensation.

In short, new duties on the part of the federal government, arising from the broad and vague terminology used in Section 5, have the very real potential of making the United States responsible -- almost as an insurer -- for private occupational toxic injuries. Accordingly, we oppose enactment of this legislation.

We are advised by the Office of Management and Budget that there is no objection to the presentation of this report from the standpoint of the Administration's program.

Sincerely,

(Signed) Jack E. Perkins

Phillip D. Brady
Acting Assistant Attorney General

cc: Honorable Rod Chandler

DOJ-1986-05

U.S. Department of Justice

Office of Legislative and Intergovernmental Affairs

Office of the Assistant Attorney General

Washington, D.C. 20530

24 JUL 1986

Honorable Don Nickles
Chairman, Subcommittee on Labor
Senate Committee on Labor
and Human Resources
United States Senate
Washington, D.C. 20510

Dear Chairman Nickles:

The following are the responses to Senator Metzenbaum's questions regarding the testimony of Deputy Assistant Attorney General Robert Willmore before the Subcommittee on Labor on May 15, 1986, concerning S. 2050, the "High Risk Occupational Disease Notification and Prevention Act of 1986."

1. In testifying about government liability under H.R. 1309 before the House Subcommittee on Health and Safety, you focused exclusively on the potential liability surrounding the Secretary's performance of his duty to notify workers. As you state in your written testimony on the bill before this Subcommittee, S. 2050 has addressed that issue. Would you agree that the additional potential for monetary liability to which you refer (liability of other federal agencies; liability under other sections of the bill; personal liability under Bivens) is likely to arise less often and on a much smaller scale than the liability arising from an inadequate government warning?

Two matters should be clarified with regard to the question. First, as to Mr. Willmore's testimony on H.R. 1309 before the House Subcommittee, Mr. Willmore did not focus exclusively on governmental liability, but also noted that the bill would most

likely lead to a substantial increase in litigation against private defendants. In that regard, his views were similar to his views expressed with regard to his more recent testimony on S. 2050.

Second, Mr. Willmore did not indicate that S. 2050 addressed the issue of governmental liability in the sense of remedying the problem. As Mr. Willmore's statement noted, Section 5(h) of the bill provides only some protection for the United States -- protection which the Department believes to be inadequate in many circumstances.

It is impossible to say whether the liability against the United States that is not addressed by Section 5(h), or the liability of Federal employees under Bivens or under State common law, would be more or less than the liability of the United States that is addressed by Section 5(h). One reason that such a comparison is impossible, and not very meaningful, is that persons who would have sued the Department of Health and Human Services absent Section 5(h), will in the alternative sue another agency of the United States (or sue for the violation of another section of the bill), or will sue the Federal employees involved in the implementation of the program. In other words, by providing inadequate protection in Section 5(h), the Section may in many circumstances do little more than require plaintiffs' attorney to reframe the lawsuit through artful pleading.

2. Could the Department's concern about protecting other federal agencies be addressed through a minor language change in

Section 5(h) of the bill -- immunizing "advisors" to the Secretary as well as the "agents" already covered?

No. It is not clear, for example, that other agencies would only be involved in an advisory capacity. Nor is it readily obvious what "advisory" means. Given the well established judicial practice of construing immunities narrowly, any immunity of the Federal government and its employees must be express, unambiguous and comprehensive if it is to be effective.

3. Of the 12,000 Bivens claims you cite, approximately how many involved a failure to warn? Were there any Bivens claims made in connection with the Swine Flu Act litigation?

It is impossible to even approximate the number or percentage of Bivens suits which allege "failure to warn" as a cause of action. It is not unusual, however, for an alleged failure to warn to be one theory of liability asserted in a Bivens case, especially in cases involving exposure to toxic substances. A similar result could be expected to pertain in suits alleging a violation of any constitutional duties associated with implementation of S. 2050.

And, of course, failure to warn is one of the most basic and common causes of action under State common law negligence doctrines.

As for Bivens claims resulting from the Swine flu vaccination program, we are unaware of any such claims. This may be the result of the exclusive remedy provision contained in the

Swine Flu Act, which provides that the "remedy against the United States . . . shall be exclusive of any other civil action or proceeding . . . against any employee of the Government . . . ."

4. If the government could have warned workers about the risks of asbestos forty years ago, and counselled exposed workers to undergo periodic screening and cease cigarette smoking, there is no doubt that thousands of lives would have been saved. Isn't it possible that this bill would actually decrease tort litigation and recovery costs by lowering substantially the incidence of occupationally-related disease?

In the abstract, a decrease in occupationally related disease should result in a corresponding decrease in tort litigation. In reality, however, this will not occur if the system which helps decrease the incidence of disease also fosters the prosecution of marginal or meritless cases. As pointed out in Mr. Willmore's testimony, we feel that the notification provisions of S. 2050 will almost certainly encourage such litigation. Moreover, even where such claims are unsuccessful, they will impose extraordinary costs on consumers and taxpayers through legal fees and other litigation expenses that often exceed (even where defendant ultimately prevails) what plaintiff would obtain in compensation even if the claim were to prove successful.

It should be noted in this regard that asbestos exposure can be a very misleading example of how this legislation would work. This is because as to asbestos exposure the evidence of a causal link -- at least with regard to the levels of exposure at issue

in the current asbestos litigations -- is now known to be very strong. This is very different from virtually all other toxic tort litigation, where the causal link often is extremely difficult to determine, and where it accordingly is very easy to mislead exposed individuals into believing that they face a serious health risk where none in fact exists.

I hope the above is fully responsive to Senator Metzenbaum's questions. The Office of Management and Budget has advised that from the standpoint of the President's program, there is no objection to the submission of this report to the Congress.

Sincerely,

John R. Bolton
Assistant Attorney General

Senator NICKLES. I am pleased that we have been joined by Senator Metzenbaum, who is the principal sponsor of the legislation.

Senator METZENBAUM. Well, Mr. Chairman, first I want to apologize to you and the others present. I asked you to set the hearing at 9 o'clock so there would be adequate time, but when I came down Foxhall Road, I just had no choice; I sat there, and so be it. That is Washington traffic.

Today's hearing addresses S. 2050, the High Risk Occupational Disease Notification and Prevention Act of 1986 which Senator Stafford and I introduced.

It calls for a reasonable Federal response to an exploding national problem: Occupationally related disease.

Millions of American workers have been or continue to be exposed to toxic chemicals, wastes, fumes, dusts, and industrial processes. Such exposures substantially increase the risk that those exposed will suffer disabling or terminal disease conditions.

The asbestos tragedy, in which thousands have died and thousands more will die, has awakened the American public to the magnitude of the problem. But asbestos is just the tip of the iceberg. Each year, some 100,000 workers die, and 340,000 more are disabled from occupational diseases.

The National Institute for Occupational Safety and Health has estimated that 880,000 workers face full- or part-time exposure to carcinogens regulated by OSHA; that 25 percent of the workforce is exposed to OSHA-regulated hazards on the job; that 40 to 50 million Americans have been exposed to one or more of these hazards during their work lives.

In short, the lives of millions of American workers go on the line every day they punch a timeclock. These men and women have an absolute right to know what risks they are taking and how to cope with those risks. To do any less is to participate in a conspiracy of silence which unnecessarily jeopardizes their lives.

Today we will hear from four victims of the silent conspiracy. Theirs is a story of devastating human costs, costs that could have been avoided through a notification and prevention program. Our responsibility to them, and to their millions of fellow employees, is to enact the bill before us.

Since Congress passed the Occupational Safety and Health Act of 1970, the Federal Government has made progress in regulating employee exposure to hazardous substances in the workplace. The efforts of OSHA, the EPA, and NIOSH have enabled us to learn more about hazardous occupational exposures and begin to limit these exposures through regulation.

Still, regulating exposures is not enough. American industry is not going to stop producing hazardous chemicals and other substances. Nor should it do so. Often the substances are essential, either as elements or as byproducts, to the jobs performed or the goods and services consumed by the American public.

What, then, can we do? Occupational disease is not going to disappear. One thing we can and should do is undertake a serious national effort to promote the prevention and early detection of occupational disease. By doing so, we will reap three enormous benefits.

First, for thousands of workers and their families, we will avoid the misery of death or disabling disease.

Second, through prevention or successful treatment, we will save millions of dollars in Federal and private health care costs. And finally, we will serve the ends of simple justice.

S. 2050 seeks to accomplish these goals through a low-cost system for identifying, notifying, and monitoring targeted worker populations.

This morning we will be listening to testimony from opponents as well as supporters of S. 2050. I welcome both sides of the debate, because I believe we need constructive criticism in order to fashion the best possible law, one that is fair to employers as well as workers; one that can be enforced effectively and efficiently by the administration.

But one thing is clear: It is too late in the day to deny the need for such a law. The working men and women of this country deserve this kind of national preventive health program. I intend to do everything I can to see that they get it.

[Additional information supplied by Senator Metzenbaum follows:]

FACTSHEET ON VICTIMS' PANEL

William Ailiff, 54, Garrettsville, Ohio. Has been diagnosed as having an organic brain disorder due to exposure to methylene chloride. Suffers from isocyanate asthma and is unable to work. Ailiff won a case before a workman's compensation judge, but his employer is appealing the ruling. For the last year and a half, he has had no income and has been forced to sell his home and a second recreational dwelling. His life savings is nearly depleted, and he has moved in with his daughter to make ends meet.

Willie Hall, 57, Augusta, GA. Worked at the Augusta Chemical Co. from 1963 to 1968, where he was exposed to beta-naphthylamine when mixing chemicals to make dyes. Hall begin to experience physical difficulties in 1967, when he was forced to make frequent trips to emergency rooms due to internal bleeding. He subsequently suffered two strokes and was diagnosed as having cancer. He has had his bladder and one kindney removed due to illness. Since 1976, Hall has been unable to work, and can only move around slowly and with great difficulty.

George Hight, 58, Bluffton, Ohio. Has worked at Cooper Tire Co. in Findlay, Ohio since 1957. From 1959 through 1976 his job consisted of mixing rubber and various chemicals. In 1980, he was diagnosed as having cancer after suffering abdominal cramps and passing blood. He underwent six weeks of experimental therapy and radiation treatment. In 1981 surgery was required and doctors removed his bladder, prostate, and part of his lower intestine. Since 1981 he has been on a different work assignment, and his travel and recreational activities have been curtailed.

Patricia Ware, 51, Villa Hills, KY. Worked at Miller Shoe Co. in Cincinnati, Ohio from 1971 through 1984. Her job was cementing outsoles on shoes, which involved breathing fumes from various chemicals. In August, 1984, she contracted pneumonia and a lung biopsy revealed interstitial fibrosis. Since then she has lost 50 percent of her lung capacity. Over the last 18 months, she has suffered numerous respiratory infections and has been in the hospital six times. She is on oxygen 10 hours each day and suffers bouts of depression and anger.

Senator NICKLES. Senator Metzenbaum, thank you. I will ask that the record include Senator Metzenbaum's statement immediately following my and Senator Kennedy's statement.

Next, we have Patrick Tyson, who is Acting Assistant Secretary for OSH. It is my understanding that you will soon be departing from the helm at OSH.

Mr. TYSON. Tomorrow.

Senator NICKLES. We appreciate that you are going to give your last day of service before this committee. I am sure it will be an easy one.

Mr. Tyson.

Mr. TYSON. Thank you, Mr. Chairman.

I would ask that my entire statement be introduced into the record.

Senator NICKLES. Certainly

Mr. TYSON. But let me try to summarize it as I can and try to maintain the 5-minute rule. Obviously, we want to thank the committee for allowing us to testify on what we consider to be a very important piece of legislation.

The Department of Labor does support the major objectives of this legislation—that is, to notify workers at risk, to encourage appropriate medical monitoring for employees who are likely to contract disease because of a specific workplace exposures, and to educate physicians in the local community about occupational diseases. We note that this bill is similar to H.R. 1309, on which we testified last November.

While S. 2050 is an improvement over its House counterpart, we still have major objections, and the Department does oppose the bill.

A major concern with this legislation is that we are already accomplishing much of the goals through the regulatory efforts that are currently underway. Since August 1980, OSHA regulations have required employers to inform their current and former employees of the existence, location and availability of medical and exposure records maintained by the employer in connection with each employee and to inform current and former employees of their right of access to such records.

The information on exposure to chemicals is available to workers under OSHA's access to employee exposure and medical records rule, which was promulgated May 1980 and became effective in August of that year.

The access rule contains a specific provision that employers must inform employees of the existence, location, and availability of medical records and must also inform them of their rights of access to those records. Former employees also have these rights available to them, though knowledge about exposure, including training about hazards, is more readily accessible to those presently employed at the worksites in question.

Further, under section 6(b) of the OSHA Act, employees must also be notified of the results of medical examinations conducted under all specific OSHA health standards issued since 1974. These standards include regulations to control workplace exposures to arsenic, lead, coke oven emissions, acrylonitrile, vinyl chloride, cotton dust, ethylene oxide, and DBCP.

It should be pointed out that any substance-specific rule would include provisions for exposure monitoring and medical surveillance. That is mandated by the OSHA Act.

Thus the initial agenda contemplated by S. 2050 is already being accomplished.

Even more directly on point are the requirements of OSHA's hazard communication standard, which becomes fully effective in the manufacturing and chemical-importing sectors within the next 2 weeks. This standard will provide better notification of current employees than even the proposed bill. The standard requires that current employees be notified of the identities of the chemicals

with which they are working. In particular, manufacturers are required to provide information when there is evidence that a chemical may result in any adverse health effect.

The standard covers a much broader range of chemicals than could be addressed within any foreseeable timeframe by the Risk Assessment Board proposed under S. 2050. It has been estimated that the standard will cover as many as 575,000 hazardous chemical products. Under the standard, employees will be trained in the hazards of any chemicals to which they may be exposed and in precautions to safeguard against overexposures. This training is likely to have a greater impact than any notice because it is workplace based, a much higher percentage of employees are likely to be informed of the hazards to which they may be exposed than would be the case through notification from lists complied by the Department of Health and Human Services.

The regulation requires chemical manufacturers and importers to evaluate the hazards from chemicals, label those which are hazardous, and prepare material safety data sheets which describe, among other things, the hazards and the precautions. These material safety data sheets must be sent to employers who use the chemicals. Those employers in turn must make them available to employees, leave warning labels on containers, and train employees about the physical and health hazards in the work area.

The information collected for compliance with the standard is likely to be disseminated to all sectors of the economy and not just those in the manufacturing sector.

In addition, OSHA has initiated the process of expanding the standard to other employers by publishing an advance notice of proposed rulemaking on November 27, 1985.

Moreover, OSHA is committed to evaluating the accuracy and completeness of these required material safety data sheets. Under a special emphasis inspection program in the chemical manufacturing industry where the standard now applies, OSHA has inspected 761 firms between November 25, 1985, and April 30 of this year; 586 of those firms were in full compliance with the provisions of the standard then in effect; 175 were not. Those 175 were, of course, issued citations as a result of their lack of compliance.

Most frequently cited were the provisions which detailed the required contents of material safety data sheets. OSHA will extend its enforcement program to the other manufacturing industries in 10 days, when the standard goes into effect for that segment of the economy on May 25.

We will inspect for compliance with the standard in every programmed inspection that OSHA conducts.

Senator NICKLES. Mr. Tyson, could you wrap up?

Mr. TYSON. Yes; let me sum it up quickly, then, if I could, Senator.

Senator NICKLES. Fine.

Mr. TYSON. What we are saying, what our position is, is that the hazard communication standard, combined with the OSHA access to medical records standard, and the existing provisions in the 20 comprehensive health standards which OSHA has already promulgated, all of which are in full effect, accomplish most of the goals, and in some way do far more than the goals that this bill envisions.

Senator NICKLES. Thank you very much.
[The prepared statement of Mr. Tyson follows:]

STATEMENT OF
PATRICK R. TYSON
ACTING ASSISTANT SECRETARY OF LABOR
FOR OCCUPATIONAL SAFETY AND HEALTH
BEFORE THE
SUBCOMMITTEE ON LABOR
OF THE
SENATE COMMITTEE ON LABOR AND HUMAN RESOURCES

May 15, 1986

Mr. Chairman and Members of the Subcommittee:

Thank you for the opportunity to present the views of the Department of Labor on S. 2050, the "High Risk Occupational Disease Notification and Prevention Act of 1986." This legislation addresses a significant goal in occupational health, namely an informed workforce. We all wish to see employees aware of the effects of occupational exposures to specific hazardous substances and processes and knowledgeable about the risk of adverse impact on health from such exposures.

The Department of Labor supports the major objectives of this legislation: to notify workers at risk, to encourage appropriate medical monitoring for employees who are likely to contract a disease because of specific workplace exposures, and to educate physicians in the local community about occupational disease. We note that this bill is similar to H.R. 1309, which was introduced in 1985, but includes a number of refinements and improvements to the House version.

In our view, the issue presented by these bills is not one of purpose, but rather of means. As you know, Secretary Brock is strongly and personally committed to efforts to

reduce the incidence of occupational disease. We at the Department of Labor recognize the importance of medical monitoring in the mitigation of serious disease, and the role notification can play in providing employees with a larger role in the mitigation of occupational risk, particularly access to an adequate medical program. To support these important objectives, however, does not eliminate our responsibility to examine S. 2050 closely, both to ensure that it can accomplish these ends, and to ensure that it can do so in a way that will not adversely affect other important goals. While S. 2050 is an improvement over its House counterpart, the Department opposes the bill.

My statement today focuses on three reasons why the Department of Labor opposes its enactment. I would like to submit for the record my testimony of November 20, 1985 on H.R. 1309, which covers additional concerns about such legislation.

A major concern with this legislation is that we are already accomplishing its goals through regulatory efforts underway pursuant to the Occupational Safety and Health Act of 1970. Since August of 1980, OSHA regulations have required employers to inform their current and former employees of the existence, location, and availability of medical and

exposure records maintained by the employer in connection with each employee, and to inform current and former employees of their right to access to such records. The information on exposure to chemicals is available to workers under OSHA's Access to Employee Exposure and Medical Records Rule (29 CFR (1910.20)), which has been in effect since August 1980. The Access Rule contains a specific provision that employers must inform employees of the existence, location, and availability of medical records and must also inform them of their rights of access to those records. Former employees also have these rights available to them, though knowledge about exposure, including training about hazards, is more readily accessible to those presently employed at the work sites in question.

Under section 6(b) of the OSH Act, employees must also be notified of the results of medical examinations conducted under all specific OSHA health standards issued since 1974. These standards include regulations to control workplace exposures to arsenic, lead, coke oven emissions, acrylonitrile, vinyl chloride, cotton dust, ethylene oxide, and dibromochloropropane (DBCP). It should be pointed out that any substance-specific rule would include provisions for exposure monitoring and medical surveillence. Thus, the initial agenda contemplated by S.2050 is already being accomplished.

Even more directly on point are the requirements of OSHA's Hazard Communication Standard (29 CFR 1910.1200), which was promulgated in November 1983. Parts of this standard went into effect on November 25, 1985, and it will become fully effective in the manufacturing and chemical importing sectors within the next two weeks, and will provide better notification of current employees than the proposed bill. The standard requires that current employees be notified of the identities of the chemicals with which they are working. In particular, manufacturers are required to provide information when there is evidence that a chemical may result in an adverse health effect.

The standard covers a much broader range of chemicals than could be addressed within any foreseeable time frame by the Risk Assessment Board proposed under S. 2050. It has been estimated that the standard will cover as many as 575,000 hazardous chemical products. Under the standard, employees will be trained in the hazard of any chemicals to which they may be exposed and in precautions to safeguard against over-exposures. This training is likely to have a greater impact than a notice. The cost of the training program, which is substantial, is born by the employer and not the Government. Because it is workplace-based, a much higher percentage of employees are likely to be informed of the hazards to which they may have been exposed than would be the case through

notification from lists compiled by the Department of Health and Human Services. Additionally under the OSHA standard, employee representatives have access to hazard data.

The regulation requires chemical manufacturers and importers to evaluate the hazards from chemicals, label those that are hazardous and prepare material safety data sheets, which describe, among other things, the hazards and the precautions. These material safety data sheets must be sent to employers who use the chemicals. Those employers in turn must make them available to employees, leave warning labels on containers and train employees about the "physical and health hazards in the work area." The information collected for compliance with the standard is likely to be disseminated to all sectors of the economy and not just to the manufacturing sector. OSHA has initiated the process of expanding the standard to other employers by publishing an Advance Notice of Proposed Rulemaking on November 27, 1985.

The detailed information which is to be provided under the standard must include any valid information available to a chemical manufacturer or an employer which shows that exposure to a substance is associated with increased risk of developing a particular disease. Employers must disclose this information to individual employees who are exposed to the hazardous chemical and must provide appropriate training about how to minimize the risks involved. The information

provided may come from many different sources, including information developed by the industry itself, Government studies, or technical information in the general literature.

Moreover, OSHA is committed to evaluating the accuracy and completeness of the required material safety data sheets. Under a special emphasis inspection program in the chemical manufacturing industry, OSHA has inspected 761 firms from November 25, 1985 through April 30 of this year. Five hundred eighty-six of those firms were in compliance with the standard; 175 were not. Most frequently cited was the provisions which detailed the required contents of material safety data sheets. OSHA will extend its enforcement program to the other manufacturing industries in ten days, when the standard becomes fully effective, and will inspect for compliance with the standard on every programmed inspection in the manufacturing sector.

To the extent that S. 2050 would require notification of current employees, it is our view that the Hazard Communication Standard provides a more efficient, broader, and more effective vehicle of communication. Information required by the Standard will be disseminated to every employee in the manufacturing sector exposed to the substance involved. Such employees will also be provided detailed information and training to limit any potential harm. In addition, because dissemination of such information will be

required for every hazardous substance, this requirement is certain to provide much broader notification than a Federal program of the sort contemplated by S. 2050, which only envisions some five substances to be studied the first year (and in the following years the remainder of the 23 substances for which OSHA has issued comprehensive health standards). Moreover, the information generated in response to the hazard communication standard will be available outside the manufacturing sector as well, even before the agency concludes its present rulemaking on that issue.

Another issue of particular concern to the Department of Labor is the extent to which decisions to notify individuals they are a member of a "population at risk of disease" under the bill's requirements could inappropriately suggest liability in workers' compensation or tort claims. The bill defines a "population at risk" as one for which the disease rate for a population exposed to a "hazardous occupational exposure" is 30% above the rate for a similar population not exposed to that hazard. The definition of "hazardous occupational exposure" has no requirement for actual exposure to a hazard for individuals in a population. Thus, for the purposes of this bill, an individual may be part of a "population at risk" whether or not that individual has been exposed to the hazard involved, whether or not that individual

has actually incurred the disease of which the population is at risk, and whether or not a case of that disease affecting an individual in the "at risk" population was caused by work-place exposure or by other causes.

It is our view that notifying individuals they are at risk in this sense could -- whatever its utility for medical monitoring -- have two adverse consequences for compensation proceedings. First, the fact that an individual has been notified under the proposed Federal legislation could, if that notification found its way into liability proceedings -- and it is likely that it will -- be interpreted as evidence of causation. Second, the notification itself is also likely to trigger the filing of many claims, whether or not harm has occurred.

S. 2050 proposes to address these problems by providing that notification and medical monitoring actions under the bill may not "constitute or in any way affect" such a claim, and that notification shall not trigger any statute of limitations. These are improvements over H.R. 1309, which does not substantially address these problems.

Even with these provisions, however, notification actions under S. 2050 could still be introduced as evidence in workers' compensation and tort proceedings. For example, a medical report from the examining physician may refer to the notification and the study on which it is based. The fact

that the claimant has been officially designated as a member of a population which the Federal Government has determined to be "at risk of disease" is irrelevant to the issue of causation in such a liability proceeding. Nevertheless, it is our belief that such notification would carry substantial weight on causation issues in liability claims, despite legislation to the contrary. We are also very concerned about the credibility that might be attributed to the population studies that form the basis of the notification. While useful for regulatory pruposes, these studies have many shortcomings, and their use as evidence of causation has to be carefully circumscribed. Under the bill, however, these studies might in effect constitute a presumption of causation, to which we are firmly opposed.

We doubt that the provision of S.2050 specifying that notification shall not trigger any statute of limitations will prevent the filing of protective claims by workers who have been notified that they have been exposed to an occupational hazard and are at risk of disease.

In addition, we are also concerned about the provision in the bill concerning the subrogation of health care providers for the costs of medical monitoring and treatment they provide. As noted in the testimony of the Department of Justice, the provision could be interpreted to mandate the payment of these costs by employers or their insurance carriers regard-

less of causation. In addition, these costs could accrue even before any disease has developed or a causal relationship has been established between the disease and employment, and thus become the obligation of the employer without regard for their nexus to a workers' compensation claim.

The third concern we have with both the Senate and House bills involves the screening mechanism for determining who will be notified by the Government that they are at risk of disease. A Risk Assessment Board of government scientists would be created to determine whether an employee population is exposed to risk of disease associated with occupational exposure. Notification of each member of a defined population of workers is required when the risk to the defined population is determined to exceed by 30 percent the risk to a baseline, comparable population.

S. 2050 includes a requirement for public comment before a determination of risk is made. This is a significant improvement over the risk assessment provisions in the original House bill, which did not allow for public participation. However, the guidelines for determination of risk which S. 2050 provides are inadequate. The "best available scientific evidence," which is stipulated as a basis for determination of risk, might be both inadequate and inconclusive or even contradictory. The inherent difficulties of

extrapolating from tests of laboratory animals to workers on the job, for example, have generated much controversy in the scientific community. There should be, at the very least, a requirement that the full weight of scientific evidence must be considered in the final determination of the Board's findings. This would be consistent with current Federal regulatory policy.

While risk assessment can be a valuable tool to guide the actions of a Government agency in setting standards, the Department does not believe that the risk-assessment criteria in S. 2050 are appropriately designed to be the basis of any official notice of risk to ordinary citizens.

As noted, the basis for requiring notification of employees under the bill is whether occupational exposures cause a 30 percent or greater increase in the risk of disease. OSHA does not believe that these conditions provide an appropriate basis for determining when an employee should be notified of a risk. The extent to which a risk to an occupational group exceeds the baseline risk to the general population for a particular disease has, in itself, only a limited relationship to the likelihood that any particular individual in that group will contract a disease. For example, a 30 percent increase in the risk of contracting a rare disease may not constitute a very substantial risk. Thus, the lifetime incidence rate of cancer of the appendix

is 14 per 100,000 persons. A 30 percent increase in that rate is an increase of 4 per 100,000 persons. It is questionable whether such an increase in a very small risk should constitute a basis for requiring notification.

We recognize that from a public health point of view it may be necessary to undertake broad outreach efforts in order to protect those whose duration and intensity of exposure to a hazardous substance, combined with their baseline health, may actually bear watching. There are serious questions, however, about triggering such proceedings each and every time a study indicates that a particular population has crossed the arbitrary threshold. Such proceedings have direct and indirect costs to the Federal government, health care providers, and the affected employees and their families. The Federal government should be allowed to take into consideration the level of absolute risk involved and the likely exposure record of the affected populations. It should be noted that the 30% rule would not only require notification in the appendix cancer example mentioned above, but it would not require notification if the risk went from 10,000 to 12,000 out of 100,000, an obviously much greater health problem. This would result in a major misdirection in the use of scarce health expertise.

In sum, after reviewing only these few aspects of S. 2050 in which the Department of Labor has particular expertise, it is our view that the combination of existing liability incentives and regulatory requirements can effectively promote the development of additional information about the risks of disease associated with exposure to particular hazards in the workplace and ensure the communication of that information to potentially affected employees. Accordingly, we see no need for the addition of a new Federal program of the type contemplated by S.2050.

That concludes my prepared statement. I will be happy to answer any questions you may have.

Senator NICKLES. Our next panelist is Dr. James Melius, Director of the Division of Surveillance for NIOSH.

Dr. MELIUS. Mr. Chairman and members of the subcommittee, I have with me today Mr. Philip Bierbaum, who is the Deputy Director of my Division. We both work in NIOSH's occupational health research group in Cincinnati, OH.

Although we share the worker notification concerns of the bill sponsors, we do not support this bill, nor do we believe that additional legislation is needed for worker notification efforts to proceed.

Worker notification is already an integral part of much of our research at NIOSH. We notify workers of the results of all medical studies, and we share study findings with employers, relevant unions, employee representatives, the Department of Labor, and appropriate State agencies.

NIOSH is also currently considering how to best conduct individual worker notification for some of our past and future studies.

We have the following specific concerns about the proposed legislation. First, the worker notification program that would be established by this bill is many times broader and more complex than any program currently envisioned by this Department and may well be impossible to accomplish.

The task of locating and individually notifying former workers who have been included in occupational exposure studies can be difficult and costly. Moreover, under the provisions of the bill, if the Secretary were to determine that a class or category of employees is a population at risk of a disease, we would be required to locate all workers in that class or category in the United States and notify each worker individually. The technical feasibility of doing this is questionable, and the costs incalculable.

Second, the criteria in the bill for identifying workers for notification could lead to notifying many workers who, in actuality, are not at increased risk. A more comprehensive and carefully developed decision logic for evaluating studies to determine risk is essential for any sound notification effort.

Third, the bill's 1-year deadline for identifying groups of workers at risk for five of the OSHA health standards may not be feasible. The preliminary studies needed to identify such groups could easily take up to 3 years to complete.

Fourth, we also have concerns about the proposed role for the educational resource centers and the environmental health centers as part of this bill, in particular their expansion to medical and social service roles.

Fifth, the cost implications of this legislation extend beyond the funding proposed in this bill and are very considerable. The bill appears to require that Social Security, supplemental security income, Medicare and Medicaid Programs, and many other health care financing systems pay for medical testing and monitoring for their beneficiaries.

Sixth, the Department already has a committee with responsibilities related to the activities of the Risk Assessment Board that would be established by this legislation. Establishment of a new board could duplicate these ongoing activities.

In addition to these concerns, I would like to point out that the legislation would require that all notification efforts involve individual worker notification. This approach is not feasible in many cases, and is not the most desirable method in many other cases. Even for the studies in which it would be feasible, it may not be the most effective use of resources. Individual notification should be an option along with the various approaches for group notification. The availability of demographic information on individuals, the probable effectiveness of various means of notification, and how the notification may duplicate the OSHA hazard communication standards need to be considered in these efforts.

In summary, although we believe that notification of workers is important, we oppose this particular legislation.

I would be glad to answer any questions that you may have about this.

[The prepared statement of Dr. Millar follows:]

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Centers for Disease Control
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TESTIMONY OF

J. DONALD MILLAR, M.D.

DIRECTOR

NATIONAL INSTITUTE FOR OCCUPATIONAL SAFETY AND HEALTH

CENTERS FOR DISEASE CONTROL

PUBLIC HEALTH SERVICE

DEPARTMENT OF HEALTH AND HUMAN SERVICES

BEFORE THE

SUBCOMMITTEE ON LABOR
COMMITTEE ON LABOR and HUMAN RESOURCES

U. S. SENATE

May 15, 1986

Mr. Chairman and Members of the Subcommittee:

I am Dr. J. Donald Millar, Director of the National Institute for Occupational Safety and Health (NIOSH), Centers for Disease Control, representing the Department of Health and Human Services. Thank you for inviting us to present our views on S. 2050. With me today are Dr. James Melius, Director of our Division of Surveillance, Hazard Evaluations and Field Studies (DSHEFS), and Mr. Philip Bierbaum, Deputy Director, DSHEFS.

Comments on S. 2050

Although we share the worker notification concerns of the bill's sponsor, we do not support S. 2050. We do not believe that additional legislation is needed for worker notification efforts to proceed. Worker notification is already an integral part of much of our research at NIOSH. We notify workers of the results of all field research, and we share findings with employers, relevant unions or employee representatives, the Department of Labor and appropriate State agencies. In addition, for all studies initiated by a request for assistance from an employer or employee representative through our health hazard evaluation (HHE) program, reports are sent to the requester and posted at the worksite for 30 days or sent directly to the affected employees. Where we have examined individuals in conducting our studies--for example, in cross sectional medical studies--we notify those involved of their individual results. Aggregate findings also are distributed through the scientific literature and through special publications available to the public and media.

Of the approximately 3800 field studies of workers that NIOSH has conducted, approximately 3400 have been HHEs in which workers have been notified through workplace postings as mentioned above. Of the remaining approximately 400 studies, 38 are cross-sectional medical studies in which workers have also been individually notified of study results, 18 are proportionate mortality studies in which we have examined only death certificates and in which there are no living individuals to notify, and 130 are industrial hygiene studies in which there was no health outcome evaluated. There are an additional 121 miscellaneous research efforts such as questionnaire studies for which individual worker notification is not a relevant concern. It is the remaining 86 studies, retrospective cohort mortality studies, about which most of the individual worker notification concern has been raised. In retrospective cohort mortality studies, we review personnel records for selected plants and determine if, as a group, the cohort experienced more than the expected number of deaths from specific diseases. Even though aggregate study results have been made available in these NIOSH studies, some have expressed concern that surviving workers should be informed individually of study results so they can seek medical consultation and other assistance if they desire to do so.

NIOSH is considering how best to conduct individual worker notification for past and future studies. Most importantly, though, if this legislation is enacted, we believe it will hinder our efforts in this area by establishing new bureaucratic structures and infeasible policy criteria, and by detracting from our other research and training mandates. Moreover, the scope of this legislation is too broad and not

defined clearly enough for it to be implemented practically. In fact, if we use the criteria outlined in the bill to identify and designate workers for notification, we will designate those who may not be at increased risk. Finally, the cost implications of the bill extend beyond the funding proposed in the bill. We have the following specific concerns about the proposed legislation:

1. The worker notification program that would be established by S. 2050 is many times broader and more complex than any program currently envisioned by this Department and may well be impossible to accomplish. The task of locating and individually notifying former workers who have actually been included in HHS occupational exposure studies can be difficult and costly. Moreover, under the provisions of the bill, if the Secretary were to determine "that a given class or category of employee is a population at risk of disease," the Secretary would be required to locate all workers in that class or category in the United States and notify each worker individually. In this case, the technical feasibility of notifying each individual in these potentially enormous populations of workers--who may have had occupational exposure but may not have been included in any HHS study--is questionable and the costs incalculable.

2. The criteria in the bill for identifying workers for notification could lead to notifying many workers who, in actuality, are not at increased risk. This would cause unwarranted distress to those workers and their families. The bill requires action on all populations for whom the risk occurs at a rate of 30% greater than in

a comparable worker population not having the hazardous occupational exposure. This is a relative risk equivalent to a standardized mortality ratio (SMR) of 130 or a relative risk of 1.3 times (130%) normal. The choice of this level does not reflect consideration of the absolute nature of the risk. Without considering the confidence interval of risks of 1.3, it is possible that the actual risk could be normal rather than increased and only appear to be increased due to statistical variation. A more comprehensive and carefully developed decision logic for evaluating studies to determine risk for workers included is essential to avoid unwarranted notifications.

3. The bill's 1-year deadline for identifying groups of workers at risk for five of the OSHA health standards is not feasible. The surveillance studies needed would each take approximately 3 years to complete.

4. The Educational Resource Centers (ERC) currently supported by NIOSH provide excellent training for occupational safety and health professionals. In addition, the ERCs and the Environmental Health Science Centers (EHS) supported by the National Institute of Environmental Health Sciences conduct significant research contributing to knowledge about hazardous substances and their effects. However, these centers in general do not currently have the medical expertise to conduct research to improve medical surveillance of employees exposed to occupational hazards. These centers are generally not equipped to conduct surveillance and to provide medical treatment and family services to employees exposed to occupational

hazards; nor do we consider this to be an appropriate Federal role. We also note in S. 2050 an emphasis on provision of social services which would move increasingly away from the expertise of these ERCs and EHS centers. Furthermore, expansion of these centers to 50 States would require extensive resources.

5. The cost implications of the legislation extend beyond the funding proposed in this bill and are considerable. The bill appears to require Social Security, Supplemental Security Income, Medicare, and Medicaid programs (and any other health care financing system) to pay for medical testing and monitoring for their beneficiaries. (We also note that the Department of Justice has raised serious concerns about potential tort liability suits against the Federal government.)

6. The Department already has a committee with responsibilities related to those outlined for the Risk Assessment Board that would be established by this legislation. Among other duties, the HHS Committee to Coordinate Environmental Health and Related Programs (CCEHRP) is chartered by the Secretary to conduct processes and efforts which encourage a balanced, objective consensus on all risk assessments and risk management procedures. Two subcommittees, on Environmental Health Risk Assessment (EHRA) and on Environmental Health Risk Management (EHRM), are specially chartered to deal with these issues. The purpose of the EHRA subcommittee is to coordinate review of risk assessment activities and investigate risk assessment issues of special interest. EHRM works to ensure the best use of available information for risk management decisions. CCEHRP includes members from all Centers and Institutes

within the Department with major responsibility to conduct programs related to the charter. The Department believes establishing the Risk Assessment Board proposed in S. 2050 is therefore unnecessary.

In addition to these concerns, I should also point out that the legislation would require that all notification efforts involve individual worker notification. This approach is not feasible in many cases and is not the most desirable method in many others. Even for many studies in which it is feasible, it is not the most effective use of resources. Individual notification should be an option along with various means for group notification. The availability of demographic information on individuals, the probable effectiveness of various means of notification, and how the notification process may duplicate the OSHA Hazard Communication Standard for current workers have to be considered.

NIOSH Individual Worker Notification Efforts

We wish to take this opportunity to report to you on individual worker notification efforts in which NIOSH has been involved. NIOSH began its first pilot project in 1977 to notify workers individually. The project comprised 55 workers whose medical records were submitted to NIOSH pursuant to OSHA's regulation of 13 carcinogens. Under these regulations, employers are required to retain records of medical examinations for workers potentially exposed to 13 carcinogens and to provide them to NIOSH upon termination of a worker's employment. The project was completed in 1979. Forty-nine percent of the workers

contacted responded by requesting NIOSH to send medical information to their physicians, which was done. However, as far as we were able to determine from follow-up, none of these workers contacted their physicians.

In 1979, NIOSH initiated a second pilot project designed to evaluate problems inherent in notifying individual workers of their potential health risks, and to identify criteria and develop a conceptual model for subsequent individual worker notification efforts. In selecting a study for this effort, we looked for a cohort on which we had demographic information indicating (1) the agent to which workers were exposed was an indisputable carcinogen, (2) the agent attacked a single organ (making the disease more easily diagnosable) (3) the number of workers was manageable, and (4) there was a known prevention method to stop the progress of the disease.

A cohort of 1,385 workers exposed to a potent bladder carcinogen, beta-naphthylamine, was selected. Of this original, 1,094 were believed to be alive and potentially locatable at the time of the study. This determination was made by reviewing records from the Social Security Administration, Internal Revenue Service and the States.

After this vital status determination was made, last known addresses had to be found via post office follow-up, use of telephone directories, tracking services, etc. Then the workers were mailed a notification message of their potential risk. Our estimate indicated that 849 workers actually received notification. Subsequently, in collaboration with

State and local health departments, a local medical college and a community action group, we established a bladder cancer screening program and an education program. A total of 655 of the 849 workers participated. For your information, 14 confirmed cases of bladder cancer were identified in this group; less than 5 would have been expected. Three of the 14 cases were identified from death certificates. Physicians' reports confirmed another seven cases that had been detected and treated independently of this project. Four cases were found in the screening process and were confirmed from pathologic reports.

Several other health and societal consequences of notification became more clear to us through this pilot project. The pilot project indicated the importance of counseling, accurate information about risk, medical screening and treatment. We believe that these needs will apply pressure to involve a larger cross section of the community, including the companies involved, unions, current employees, physicians, lawyers, the insurance industry, social services of State and local government, and members of the community at large. It is important to note that one result of this pilot notification was that some $300 million in law suits were filed against the companies involved.

These factors should not dissuade us from pursuing appropriate worker notification, but they do suggest the seriousness of these activities and provide guidance in conducting them. Three concerns are critical in this respect: (1) special care has to be taken to avoid what we call "false" notifications (worker notification must be based on scientifically sound judgment and information); (2) accurate information should be available

to workers, their families, and community physicians and other entities; and (3) communities, the medical system, and State and local agencies need to be prepared to respond to needs which may include counseling, medical screening and treatment.

Based on the results of these pilot projects, we have developed a draft decision logic for determining which of our studies should be considered for inclusion in an individual worker notification effort. We also have developed a list of candidate studies (where overall dissemination of results already has taken place) to which the decision logic will be applied. Both the decision logic and the list are receiving review from our Board of Scientific Counselors. We hope this process will be completed soon. We will, of course, continue to conduct our mandated epidemiologic studies of workers and will use the worker notification decision logic for these studies.

In summary, although we believe notification of workers is important, we oppose this legislation. For the large majority of our studies, we already notify workers at increased risk of disease. For the remaining group of studies not included in these efforts, our retrospective cohort mortality studies, we have efforts underway to begin a notification program for those workers.

This concludes my testimony. I would be happy to answer any questions at this time.

Senator NICKLES. Dr. Melius, thank you very much. I appreciate all our panelists' willingness and cooperation to keep your remarks limited.

Dr. Melius, you mentioned that you have six specific problems.

Dr. MELIUS. Yes.

Senator NICKLES. One was cost. Do you have any idea what it would cost to implement this legislation?

Dr. MELIUS. Yes; it would be considerable. First, you would have to set up the Risk Assessment Board and a staff to function with that. You would also have to set up funding for the environmental and resource centers that would be established under this bill.

If one tried to hire physicians and social service people and to set up training programs for these centers, it could easily run on the order of $1 million per center per year for the first 10 centers. For the next 40 centers—or at least 40—that are required under the bill, there would also be considerable cost.

However, I think the most serious costs involved with the bill would be the actual notification efforts. We have done some calculations at NIOSH to try to determine how much it would cost to notify different groups of workers individually. We estimate that the cost per worker would run somewhere between $40 and $55. It is very hard to come up with an exact figure because of how broad the language in the bill is in terms of risk groups, as I mentioned in my testimony.

Now, if one applies the above estimates to some groups out of the 24 standards mentioned in the bill, one can come up with very considerable costs. For some groups, it may be very small because many of those standards apply only to small groups.

Take, for example, a substance such as lead. In 1980, when OSHA proposed their lead standard, they estimated that 800,000 workers in this country were employed in industries with significant lead exposure. If we estimate that we could screen out certain of those workers, that some would already be notified, even breaking that down to only half of the 800,000 workers, we come up with costs in the range of $16 to $20 million to locate and notify those lead-exposed workers.

In addition to those 800,000 in primary lead industries, there are also an estimated 2.4 million workers in other industries that used lead and lead compounds. Now, it is very difficult to determine what percentage of those must be notified under the act, but it is certainly very conceivable that another 400,000 would have to be notified. And therefore, one can easily predict another $16 to $20 million to notify that group of workers.

So for lead alone, one can see costs on the order of $30 to $40 million to notify lead-exposed workers under this bill.

Now, lead is not, I think, an exaggerated example. There are many other groups in that first 24 that have a considerable number of workers currently exposed. Estimates from some NIOSH studies in the early seventies were that approximately 500,000 workers were exposed to asbestos at that time; ethylene oxide, which is a recent standard, has on the order of 100,000 workers, many of them in smaller industries, hospitals, and so forth.

So we see a very considerable cost involved and a very difficult task in trying to notify workers under this bill.

Senator NICKLES. You are an M.D. and I am assuming, a toxicologist, or you work in that field. How difficult would it be to notify 400,000 or 800,000 or 2 million people of lead exposure? Is there anything that could be done, or what would be the results? Are you going to scare those workers that maybe worked in an oil refinery in Oklahoma or someplace?

Dr. MELIUS. It depends on how specific one can be about their exposure. One of the problems in notifying this large a number of people is that there are not good records available. There may not be good information on their actual risk. All we would know is that they worked around lead and may have had considerable exposure within that industry. We would not always be providing very good information on risk for that worker. We would be telling them that they may be at increased risk for kidney disease, for hypertension, and possibly, for neurologic effects from lead.

In terms of what they would be able to do from there, I think it is uncertain. Clearly, the most important thing for a lead-exposed worker would be to no longer be exposed to lead and to control that exposure; that has been done under the OSHA standard for lead. So ongoing exposure has been prevented.

Senator NICKLES. Mr. Tyson, Dr. Melius used an example to describe notifying workers of just one subtance, where we are talking about lead. When OSHA promulgates the standard on exposure to certain substances, are there any requirements other than the exposure limits?

Mr. TYSON. Absolutely, Mr. Chairman. The act itself is very specific that whenever OSHA promulgates a new health standard—and the ones we are discussing today are all what we consider to be new health standards—you have to consider not only an exposure limit for that substance, but you have to consider the issue of medical surveillance, what appropriate medical testing should be done to employees to detect early signs of disease associated with the exposure to those substances. You have to do exposure monitoring to determine exactly what the workplace levels are during the periods of the working day for those employees who may be exposed. You have to have provisions for labeling and warning signs, which will tell employees about the hazards that are associated with the substance.

All of those issues have to be considered in any new health standard that OSHA promulgates, and have been since 1974.

Senator NICKLES. You mentioned your right to know standard that is going into effect in 10 days covers just manufacturers. Are there any plans to expand the scope beyond manufacturers?

Mr. TYSON. Yes, sir. We published an advance notice of proposed rulemaking last November, and we are moving actively to expand the scope of that standard.

I should note that even though there is no direct application of that standard to areas beyond the manufacturing segment now, there is clearly an indirect effect, because material safety data sheets and labeled products which are going to move into the manufacturing sector will inevitably find themselves in all segments of the economy. Even though not required by OSHA law, considerations of liability will almost mandate that that take place.

Senator NICKLES. If you happen to be a service industry that happens to be using solvents of some kind, you might not be covered under this rule, but you are saying that that solvent would have whatever appropriate label?

Mr. TYSON. In all likelihood, that label will be there, and you will have the opportunity to get a material safety data sheet, which contains much more specific information on that substance, including health effects, including what you need to do to protect yourself from those health effects. And in all likelihood, the distributor of that product to you is going to make that safety data sheet available.

Senator NICKLES. Mr. Willmore, you mentioned a couple of problems that you could see, one being enormous increased litigation. You also mentioned the possibility of liability for U.S. employees, and I am assuming by "employees," you are talking about inspectors under NIOSH or Department of Labor or HHS. Would you care to expand on that for a minute? How would Government employees have increased liability under this legislation?

Mr. WILLMORE. Well, I think there are many different avenues under which Government employees might have increased liability: Inspectors, but also individuals who do relatively ministerial activities, such as the individuals who might be asked to try to find the employees to whom notices are to be sent; even employees who have the responsibility for sending out or following up on the notices.

Senator NICKLES. Is there a requirement in the bill for Federal workers, or would it be toward the employer?

Mr. WILLMORE. As the bill is drafted, it would be for the Federal Government and Federal employees. The bill provides that employers and governments could be certified—presumably, this is a voluntary certification process—to engage in much of that activity.

As we noted, however, because the immunity that the bill provides is only immunity under Federal law, and most of those employers and governments will be liable under State law, it is really an illusory immunity. And therefore, I think you are going to find it very, very difficult to certify anybody. There may be a few, but I think many people are going to be very reluctant to volunteer for such certification. Accordingly, I think the burden is going to be on the Federal Government.

To the extent that the United States itself is protected under this statute—and as we have noted, we think the protection is very inadequate—but to the extent it is protected, many plaintiffs will look around and sue the Federal employee because they cannot sue the government. They will either sue the employee under a Bivens claim—a constitutional claim—or as is increasingly the case now, they will sue under common law State doctrines. And to reiterate section 5(h) of the bill does not refer to liability under State law.

I would add that this may have very significant budget implications, putting aside the effects on the employees, because I think that the agencies may be forced to seek authority and use the authority to indemnify these employees. If that happens, then that is just an indirect way of getting the money from the Government.

Senator NICKLES. Would liabilities be arising from failure to notify if they were not included in a group that possibly should have been included in a group?

Mr. WILLMORE. It could be a number of things. It could be something very technical, such as a failure to use the right mailing list, or a failure to follow up on the notice in the right way, or a failure to aggressively pursue leads in trying to track down past employees. It also could be something very fundamental, such as defining the appropriate latency periods. Perhaps it will be alleged that the wrong latency was identified. After the fact, plaintiffs' attorneys might be able to show that if one study had been followed rather than some other study, a different latency period would have been identified. A court might then have to adjudicate whether it was reasonable or negligent to use one study rather than another.

Senator NICKLES. I appreciate your comments.

Senator Metzenbaum.

Senator METZENBAUM. Dr. Melius, under the 1986 retrospective cohort mortality studies referred to in your testimony, what is the total number of workers whom NIOSH has determined are at potentially increased risk of cancer or other work-related disease, but who have not been notified of that risk?

Dr. MELIUS. We could provide you with the number that are in that study. The problem with those studies is, we have not gone through the process of determining who is at risk or who is not. We have a list of potential——

Senator METZENBAUM. I know, but how many—aren't there 250,000 in your own study that are at risk from cancer; haven't you stated that in your own study?

Dr. MELIUS. Among our studies, that sounds like a reasonable estimate of the number of people included. The number at actual risk is unclear. It depends on the definition of risk. And we are currently trying to develop a definition of risk that would help to decide how to go about notifying those groups.

We have conducted two pilot studies of notification efforts. One involved some records we had on a group at risk of developing bladder cancer. For that group we actually did conduct a notification effort.

Senator METZENBAUM. I guess I would just ask you to answer my question. Didn't your study indicate that there are approximately 250,000 workers who are at risk of cancer or other work-related diseases but who have not been notified of that risk?

Dr. MELIUS. Approximately 250,000 among our retrospective cohort mortality studies have not had individual notification of the results of those studies.

Senator METZENBAUM. So the answer is "Yes"?

Dr. MELIUS. The answer to that is "yes," as stated.

Senator METZENBAUM. Within the last 6 months, has NIOSH done any studies or given any written consideration to the cost of notification under the proposed Federal legislation?

Dr. MELIUS. Yes, we have. Some of those were the estimates that I provided earlier.

Senator METZENBAUM. And what were those results, that it would cost $40 to $55 to notify those who were no longer working; is that your point?

Dr. MELIUS. Yes, it would cost that much to track down and locate the plants, to determine who was exposed in those facilities and whether the people in those facilities met a definition of risk. One can only make an estimate of that because it would depend on the findings of the Risk Assessment Board. Then we would have to obtain the records, to obtain current addresses on those people, and then to track them down and notify them. We estimate that the cost would range from $40 to $55 per person. It would depend on a number of factors including the size of the plants involved, the number of workers, and the amount of effort in locating those workers.

Senator METZENBAUM. And would you make a copy of that study by the Division of Surveillance available to the committee, please?

Dr. MELIUS. Certainly, we can write out and provide the details of that under different scenarios.

Senator METZENBAUM. If we are talking about $40 to $50 an employee, how many employees would be involved that would have to be notified under your estimate?

Dr. MELIUS. It would depend on the substance involved. The above is a generic estimate, based on notifying any worker. It would depend on the number of workers involved under the different criteria that were chosen by the Risk Assessment Board.

Senator METZENBAUM. Dr. Melius, have you made any comparison as to that total cost with respect to notification of workers and the long-term costs if they are not notified, including to our society, to Medicare, to Medicaid, to health programs administered by the employers? It seems to me that that is a very modest amount of money compared to what the real impact may be if a substantial proportion of those workers who are not notified come down with serious illnesses.

Dr. MELIUS. That is certainly something that has to be considered. It would be something that I think would be very difficult to estimate, because one would also have to know what the beneficial effects of the notification were per se.

Senator METZENBAUM. Would you not normally say that an individual who has been notified that he or she has been exposed to serious substances which may result in illness has a far better chance of protecting his or her life in the future after that notification, even though it is an accepted fact that even with notification, in some instances, there is nothing you can do about it; but you would still have a better chance if you knew the facts, wouldn't you?

Dr. MELIUS. Yes, but the better chance would depend on the particular substance, the particular disease, and what could be done to prevent that after the exposure has occurred.

Currently, our primary public health effort is to control and prevent exposures. In these instances, we are talking about people who have been overexposed in the past and are now at risk of disease. It very much depends upon the availability of screening tests and on what other steps those persons may take to lower their risk.

Senator METZENBAUM. And in 1977, at a hearing before this subcommittee, the directors of NIOSH and the National Cancer Institute testified that the use of demonstration projects was the best

way to develop an effective and efficient approach to worker notification.

Are you at all concerned, Dr. Melius, that nearly 10 years later, notification of workers known to be at risk has not progressed to any substantial degree?

Dr. MELIUS. We certainly are concerned about that.

Senator METZENBAUM. Now, in your testimony, you stated that two demonstration notification projects have been funded since 1977. How many workers were covered by those projects?

Dr. MELIUS. A few thousand, at the most. I believe the other was a very small study, based on some records that were sent to us. Both were designed to look at different approaches for notification and what the effects of those notifications would be.

Senator METZENBAUM. Has NIOSH made other requests for worker notification funds from HHS since 1977?

Dr. MELIUS. Yes, sir, we have.

Senator METZENBAUM. With what results?

Dr. MELIUS. Through our own Centers for Disease Control, we have received funding for some initial efforts in worker notification. We currently have some activity under way to gather these studies together and to make a determination on what would be the best approach for followup.

Senator METZENBAUM. Well, in the total that you have done since 1977, you have only notified 1,200 people in the entire period. If you were to notify 300,000 workers, in an effort to explore this subject, the whole cost would only be about $15 million, which is well within the $25 million budget figure that this piece of legislation has.

Don't you think you would learn substantially more about the value of notification if you had a far larger test group?

Dr. MELIUS. We certainly could, although again, as I expressed earlier, our concerns under the bill are that the definition of risk is so broad that it really would not address that larger population that is out there. One would like to look at different approaches for doing that.

As I mentioned, individual worker notification may not be the best approach for many of these groups. For some, it may no doubt be needed. For others, there may be more effective ways of reaching these people. Perhaps many are already being reached in their own workplace. We really do not have good information on that.

Senator METZENBAUM. Dr. Melius, would you be good enough to make available promptly to this subcommittee the report that you are about to issue from your Board of Scientific Counselors on the decision logic for which workers to include as part of your notification effort?

[The report referred to follows:]

REPORT OF THE

SUBCOMMITTEE ON INDIVIDUAL WORKER NOTIFICATION

NIOSH BOARD OF SCIENTIFIC COUNSELORS

February 15, 1986

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NIOSH Board of Scientific Counselors
Subcommittee on Individual Worker Notification
Meeting Report
October 18-19, 1985

INTRODUCTION

The Subcommittee on Individual Worker Notification met on Friday and Saturday, October 18-19, 1985, to discuss the proposed NIOSH decision logic for selecting the retrospective cohort mortality studies of which the individuals should be notified. Members of the Subcommittee and outside consultants to the Subcommittee are listed in Appendix 1. As an introduction for the subcommittee, NIOSH staff presented the following information:

> The National Institute for Occupational Safety and Health (NIOSH), in accordance with the Occupational Safety and Health Act and the Federal Mine Safety and Health Act, conducts a wide range of research activities on health and safety issues related to the workplace. In many cases, NIOSH provides notification of the study results directly to the individuals involved. For example, in health hazard evaluations, which are requests by employers or employee representatives for assistance at the worksite, NIOSH sends results of the studies to the requester, the company involved, employee representatives, union headquarters, the Department of Labor, and appropriate State agencies. In addition, final reports are either posted at the worksite for 30 days or are sent to the affected employees. The results of any medical tests performed on individuals are reported directly to the individuals themselves and to the health care provider designated by the employee. Every year NIOSH conducts approximately 550 health hazard evaluations involving thousands of employees and, in each instance, follows these practices routinely.
>
> For epidemiological studies other than health hazard evaluations (such as mortality studies), NIOSH also follows the above procedures with the exception that results are not posted at the workplace (because the involved businesses are frequently multiple and in many locations) nor sent to the affected employees unless medical tests were performed. For all medical tests, NIOSH reports the results directly to the individuals and the individuals' designates.
>
> Public attention has been focused on the Institute's individual worker notification policy for the type of epidemiologic study called the retrospective cohort mortality study. These cohort studies involve a review of records from various sources but very rarely involve direct contact with individual workers. In fact, NIOSH does not usually receive information about an individual worker that the company or the worker does not already have. Essentially, these are statistical epidemiologic studies in which NIOSH extensively analyzes all available data on the research

topic. From the data gathered, NIOSH develops general, aggregate information about trends and potential risk factors for groups of workers. NIOSH provides these aggregate data to the companies, to other sources that have provided records for review, to relevant unions or employee representatives when they exist, and to the Department of Labor and appropriate State agencies. The findings are also distributed through the general scientific literature and through special publications that are available to the public and the media. Any company or union may inform current or previous employees of the study results. The degree to which aggregate information analyzed for a cohort, may be applicable to any individual in the cohort, is a major, and unresolved, issue.

NIOSH has considered the important issue of whether or not individual workers who were included in cohort mortality studies should be individually notified of the results of the study, and how they should be notified. The Institute has concluded that in general, these workers should be individually notified where a significant risk was identified by the study. Major issues as yet unresolved are what is a "significant risk," which cohorts should be notified, and how this should be done? The measures ultimately selected, must be prudent and compassionate so as to minimize any adverse consequences to the workers receiving the information.

NIOSH has developed a "decision logic" for determining which study cohorts should be selected for notification. Obviously, it is imperative that the decision logic be scientifically sound. Therefore, a review and assessment of the scientific quality and appropriateness of the proposed "decision logic" and its application is needed.

Background

Since 1977 questions have been raised about whether the surviving subjects of cohort mortality studies should be notified of study results (1) because they have a right to that information; (2) because NIOSH has an obligation to inform them; or (3) because both a right and an obligation are involved.

The opinion of the HHS Office of General Counsel is that currently there is no legal responsibility for NIOSH to notify these subjects. The CDC Ethics Committee has also considered this issue. Although it has not produced a final report, the draft report accepts the basic view that some risk circumstances create an obligation to inform, particularly when NIOSH is the exclusive holder of data, and when there is clear evidence of a cause-and-effect relationship between an exposure and a health risk.

In 1977 the issue of worker notification was raised in hearings before the Subcommittee on Labor of the Senate Committee on Human Resources. In response to questions about NIOSH'S practices, the

then Director of NIOSH, Dr. John Finklea, indicated that NIOSH ensured in a variety of ways that research results were widely available to management, labor, academia, and in the public domain, but that the Institute did not notify individual subjects of results because (1) many of the logistical issues pertaining to individual worker notification were unresolved; (2) the high cost of notification had to be considered; (3) there is a need for subsequent medical surveillance after notification and such medical surveillance is not within the purview of NIOSH; and (4) there are problems inherent in notifying individuals when no effective early detection method is available. Although not voiced specifically at the hearings, there was internal concern among some NIOSH employees that findings from cohort mortality studies might not be pertinent to the risk status of individuals.

Subsequent to the 1977 hearings, NIOSH has embarked on various projects aimed at evaluating the problems of notification and identifying possible solutions. In 1977 a report entitled "Practical Problems and Policy Issues Arising from Exposures to Hazardous Chemicals and Physical Agents in the Workplace" was submitted to the Senate Subcommittee. This report was a first step in providing an overview of the problems inherent in individual worker notification.

In 1979, NIOSH completed a small pilot study of individual worker notification of a selected group of 55 terminated workers, whose medical records had been submitted to NIOSH pursuant to the provisions of the Occupational Safety and Health Act and the Occupational Safety and Health Administration's regulations on 13 carcinogens (29 CFR Part 1910.10). The workers were sent letters that told of possible exposure to a carcinogen. No medical surveillance or follow-up was planned. Forty-nine percent of those who presumably received a letter responded by asking NIOSH to send medical information to their physician. However, on the basis of a telephone survey, none were known to have contacted their physician. It was estimated that the cost of this notification alone was about $150 per worker notified.

In 1980, a major pilot study was begun (1) to evaluate the problems inherent in notifying individual workers of their potential health risks, and (2) to identify criteria and develop a conceptual model for subsequent notification efforts. A cohort of 1,385 workers exposed (in Augusta, Georgia) to a potent bladder carcinogen, beta-naphthylamine, was selected. Of this original cohort, 1,094 were believed to be alive and potentially locatable at the time of the study and were notified by mail of their potential risk. Our best estimates indicated that 849 workers actually received notification. In collaboration with State and local health departments, a local medical college, and a community action group, a bladder cancer screening program and an education program were established with 655 workers participating. Four new cases of bladder cancer were found as a result of the notification program. Fourteen cases were found in all--3 from death certificates and 7

cases were detected and treated independently from the notification effort. This study showed that individual worker notification is merely the first step in a long and complex process. It confirmed that notification can be achieved, but that there is a need for subsequent provision of information, for medical surveillance, and for support programs for those notified and sometimes for their families.

The Augusta study also included an evaluation of the assumptions implicit in a notification program, and more specifically it addressed the questions of whether the results of epidemiological studies were applicable on a individual clinical basis. It was concluded that for the workers in this study such information is applicable.

Within the Institute there is no single list of people at risk; rather, there are records of a variety of study types with divergent results that need individual evaluation as to whether there might be potentially notifiable risks. A working group within NIOSH has inventoried all previous and ongoing NIOSH epidemiological studies and has categorized them roughly into groups that might be candidates for notification.

Subcommittee Charge

What NIOSH requested from the Board of Scientific Counselors Subcommittee on Individual Worker Notification was a review and assessment of the scientific quality and appropriateness of the proposed "decision logic".

Specifically the charge was:

1. Review the scientific validity and consistency of the NIOSH "decision logic", and

2. Review the application of that "decision logic" to a group of epidemiologic cohorts so as to evaluate the propriety of the implementation of the "decision logic".

The charge to the subcommittee concerned the possibility of additional notification of individuals involved in retrospective cohort mortality studies. Currently, this involves companies and local union representatives and appropriate State agencies which are notified about the results of these studies. It should also be noted that the subcommittee was only requested to review criteria for individual notification of cohort mortality studies. NIOSH has also collected data which define groups at high risk based on cross-sectional medical studies case control studies and on industrial hygiene studies. Separate criteria will need to be developed for these groups.

RECOMMENDATIONS TO DIRECTOR, NIOSH

The purpose of the meeting was to conduct a scientific review of the "decision logic" and to review its application at a later date. After the one and one half days of deliberation regarding the NIOSH decision logic the following recommendations are made to the NIOSH Board of Scientific Counselors to be forwarded to the Director, NIOSH.

Retitle the decision logic to "Guidelines for Notification of Individual Workers".

These guidelines are meant to be flexible and applied on a case-by-case basis. We must stress that these recommendations are meant to be guidelines; they are not to supplant scientific interpretation and judgment. The cohort studies under consideration are complex and we consider it inappropriate to apply simple, rigid rules to complex studies.

A. Determine that the study is appropriately designed and analyzed.

The study needs to be carefully reviewed in the context of questions such as:

1. Was an appropriate hypothesis formulated for the study?

2. Was the study population appropriate and of sufficient size to address this hypothesis?

3. Is there adequate documentation of cohort selection? Could this selection be biased?

4. Was there adequate follow-up of the cohort?

5. Were the causes of death adequately documented particularly for diagnoses where death certificate data needs confirmation?

6. Were appropriate statistical methods used to analyze the collected data?

7. Are the risk estimates from the study reliable? The determination will include confirmation of the definition of the study groups and the confidence of the study results.

All of these factors (and others) need to be reviewed in determining whether the study is appropriately designed and analyzed.

B. Consider whether the findings are consistent with those of other studies.

The study results then should be reviewed to determine whether other information supports the conclusion of the study. This other

information may come from animal studies, other human health studies, accepted mechanisms of action and metabolism to substances having similar activities. Biological plausibility should also be considered. Findings consistent with this other information would be likely candidates for notification. A finding not supported by other studies would need much greater evidence of elevated risk to be considered for individual notification.

C. Establish whether the survivors are or are not at risk.

Another important aspect of a notification decision is a determination that the survivors are still at risk from their previous exposure. Often the lack of information will make this difficult to determine, and the cohort will have to be assumed to still be at risk. However, in some instances, a change in production process control or a substitution in the process will place a subpopulation of the cohort survivors at much less risk than cohort members who worked prior to the change. This will have to be very carefully determined before deciding not to notify on this basis.

Another consideration is that of the selection of only certain cohort groups for notification. In some cohort studies it may be possible to identify a portion of the cohorts who are at increased risk as compared to others in the study. This selection will usually be based on work in certain areas of the plant with unique or much greater exposure to the toxic substance. This differential notification will have to be very carefully reviewed prior to leaving certain cohort members out of the notification process.

D. Determine that the cohort has not been previously notified.

The review of each cohort study must also address whether the cohort has already been notified. This may have been done through special screening programs at the plant or other efforts. If over seventy five percent of the group has already been notified no further notification is proposed. As with other criteria, this cut off must be judged with flexibility. The nature of the previous notification effort, the information included in that notification and its timing would need to be assessed.

E. Notification Options: The following options are sufficient but not necessary criteria to trigger notification actions. Other factors to be considered include the potential for medical intervention (treatable disease) or other steps which would alter the eventual individual risk. Also, it is important to reduce false negative and false positive notifications.

1. If the attributable risk[1] is at most 25 percent (or the SMR[2] is greater than 133), and the absolute risk[3] is less than 10^{-3}, then:

   a. Employers and union representatives for the same type of industries should be notified of the results through a general notification effort.

   b. The cohort should be notified through information on the study being provided to the involved company and union officials and, where possible, posting of the report in the involved locations.

2. If the attributable risk is between 25 and 50 percent (or the SMR is between 133 and 200) and the absolute risk is between 10^{-3} and 10^{-5}, then:

   a. Notify the involved industry and unions as outlined in E.1. above.

   b. NIOSH Alert: Through appropriate mechanisms such as a Hazard Alert, NIOSH should take active steps to notify the industry and work force of the hazard.

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1 As used here, attributable risk (AR) is synonymous with the terms attributable risk (exposed) or attributable fraction (exposed) as defined by JM Last in A Dictionary of Epidemiology, p.7. The definition as adapted to mortality studies is as follows: In a situation in which exposure to a given factor is believed to cause a given outcome, the attributable risk among the exposed is the proportion of the outcome among those exposed to the factor that can be attributed to the exposure factor. In these guidelines, it will be expressed as a percent. It is computed as: AR = (SMR-100)/SMR. For example, if the SMR for a specific disease is 133, the AR would be (133-100)133 = 0.25 or 25%. If information on other risk factors was available, appropriate adjustments in attributable risk could be made. However, this other information is usually not available.

2 The Standardized Mortality Ratio (SMR) is the ratio of the number of deaths observed in the study population to the number of deaths expected if it had the same rate structure as the standard population. An SMR that is greater than 100 indicates an excess of observed deaths in a study populations.

3 As used here, absolute risk represents the actual risk in a population, that is, the probability of cause-specific deaths occurring within the lifetime of the population. Absolute risk is expressed here in a shorthand form according to orders of magnitude. For example, an absolute risk of less than 10^{-5} means that the risk of dying of a given disease in a population during its lifetime is less than 1 in 100,000.

c. Notify the local newspapers and media in the areas where the cohort is located of the findings of the study and the implication of these findings for the study participants.

d. Notify the appropriate public health agencies.

3. If the attributable risk is greater than or equal to 50 percent, (or the SMR is greater than 200) and the absolute risk is greater than 10^{-3}, then individual worker notification will include:

a. Efforts to locate individual members of the cohort.

b. Individual letters of notification to the cohort participants informing them of their assumed increased risk.

c. Notification of noncohort workers which will be the same as E.1 and E.2.

d. Appropriate provision for workers to contact NIOSH personnel to obtain further information.

When considering this option and when individual worker notification takes place under E.2., the provisions for support services in connection with notification must be thoroughly evaluated before proceeding.

Note: The three options do not cover all possible combinations of absolute and attributable risk. When studies have risk combinations that do not meet the options as described great care should be taken to ensure the appropriate worker notification option is applied.

F. Other Recommendations

In considering the above guidelines, again flexibility and case-by-case decision making are to be utilized. Additional considerations that the Director of NIOSH should use for the individual decisions include:

1. When considering the SMR the comparable population should be reviewed carefully. National statistics may not always be appropriate.

2. Attributable risk as defined should be given greater weight than the other criteria.

3. The setting of a limiting statistical p value is probably not appropriate for this use.

4. Adjustment for simultaneous inference should be used cautiously and only if the unadjusted estimates of probability are also presented.

5. Individual worker notification as described in E.3. would be used if worker notification as described in E.2. is not possible because the plant is closed and the cohort is geographically dispersed or if selected groups within the cohort have a much higher risk.

6. Decisions regarding individual worker notification after the guidelines have been applied by NIOSH to their studies should be audited by an external peer review group.

7. The notification effort, after implementation should be evaluated for effectiveness. Early efforts should be fully evaluated, with periodic evaluations thereafter. There should be a behavioral scientist on the evaluation team. The primary questions to be answered are:

   a. Were the individual workers notified?, and

   b. What happened after notification?

8. Systems should be in place to deal with health inquiries stimulated by the worker notification and to provide health care as may be appropriate.

9. There should be a disproportionate use of resources for those subjects of cohorts at greater risk.

In summary, the Subcommittee recognizes that there are different levels of intensity of notification and that there should be different criteria for each. The Subcommittee appreciates the uncertainty implicit within the guidelines, on the other hand, the Subcommittee believes the guidelines are necessary and valuable to a thoughtful, careful review of the cohort studies. Both the NIOSH internal review committee and the external peer review committee have the flexibility to reclassify a study cohort. Again the Subcommittee is especially concerned about minimizing both false negatives and false positives.

Some of these recommendations are made with the knowledge that they may exceed the authority of NIOSH. When this occurs every effort should be made to ensure that worker notification takes place through investigatioh of alternatives, such as, working with other government agencies.

ISSUES THAT WERE DISCUSSED DURING THE DELIBERATIONS

The members of, and the consultants to the Subcommittee expressed various positions regarding the following issues discussed. The Board of Scientific Counselors should not consider the views expressed as an indication of a Subcommittee position.

A. Objectives of Notification

1. An Ethical Objective of Notification

This objective is limited and is consistent with the draft CDC Ethics Committee report which accepts the basic view that some risk circumstances create an obligation to inform, particularly when NIOSH is the exclusive holder of data, and when there is clear evidence of a cause-and-effect relationship between an exposure and a health risk.

2. A Public Health Objective of Notification

This focuses on the public health consequences of some action. In this situation the argument is to proceed with individual worker notification but to go beyond just the cohorts studied. There was some concern that as a result of the notification effort cohorts, essentially selected at random, would receive the benefits of a screening program or other medical intervention while there may be other workers with similar work experience who are not notified and therefore not accorded the same opportunity. The public health objective as stated goes beyond NIOSH's intent to notify just the involved cohorts.

3. Civil Rights Objective of Notification.

This focuses on the right of all persons in a study to be notified regardless of the study outcome. In essence, individuals who participated in a negative study should be notified with the same effort accorded those who participated in a positive study.

The argument offered is that the three objectives are inextricably linked; that one necessarily leads to the other. The NIOSH proposed decision logic meets the ethical objective but when considering the public health role of NIOSH we are also considering both the public health objective and the civil rights objective.

There was extensive discussion on these three objectives and the impact they should carry regarding the NIOSH proposed decision logic. The dichotomous positions were 1) full notification and 2) notification of industry and unions which will assume the responsibility of individual worker notification. The second position argues that industry and unions have the responsibility to protect workers and rightfully they should bear the burden of individual worker notification, not government. There was no

resolution to this debate but the Subcommittee took it into consideration when making its recommendations.

B. Minimum Notification

An issue closely linked with the civil rights objective is the issue of minimum notification. The argument being that consistent with the civil rights objective all workers should be notified albeit at varying levels of intensity of effort. Notification efforts would be made for cohorts of studies with negative results or very low risk. The Subcommittee believed the benefit to be marginal and the costs in anxiety generated, medical cost, litigation, and the diversion of resources that could be put to better use elsewhere, to be too high so that no recommendation for minimum notification was made.

C. Application of Group Data to Individuals

Another broad issue is that NIOSH is proposing to take aggregate data and apply it to the individual case. Retrospective cohort mortality studies conducted by NIOSH investigate groups for the purpose of contributing to development of public health knowledge and the Federal government's standards development process. The notion of individual worker notification requires taking group data and applying it to the individual case. There is a threefold concern:

1. Is it valid to take epidemiologic data and apply it to the individual case?

2. Are the thresholds within the "guidelines" valid for the individual case (i.e., rigid adherence to the criteria)?

3. Are the criteria for decisions made within the realm of public policy (i.e. standards development) appropriate in the individual case?

This is of particular interest when considering absolute risk levels. Such criteria are used for development of regulations and have never been discussed regarding individual assumption of risk and the concomitant effort of individual worker notification. Again, these were taken into consideration during deliberation.

D. Ethical, Social, and Economic Issues

The Subcommittee believed that ignoring ethical, social, economic, and other considerations was not possible. While the Subcommittee agrees that the general process of worker notification is sequential, the specific events are interrelated and should not be treated as mutually exclusive. Given that events are not mutually exclusive, then a NIOSH proposed decision logic cannot be reviewed without also considering the method of notifying individual workers.

There was general agreement that the NIOSH proposed decision logic should be "coupled" with the form of the message. We must recognize that there is a spectrum of options for notification and to ignore the form, to narrow the focus of the discussion on only the NIOSH proposed decision logic, will not stand the test of public scrutiny. The decision of the Subcommittee was to address both the NIOSH proposed decision logic and the method of notification.

E. Rigid Criteria Versus Flexible Criteria

The Subcommittee believed the decision criteria should be flexible. Retrospective cohort mortality studies, by their very nature, are complex studies. For instance, determining true excess risk, determining confidence intervals, accounting for cofactors or confounding variables, and minimizing biases make definitive results difficult. The Subcommittee believed that there was no random sampling and recommended against reliance upon the p value as a firm criterion to be used in the NIOSH proposed decision logic.

Generally, the Subcommittee believed that there was a need for more flexibility in the NIOSH proposed decision logic allowing for interpretation and judgment. The idea of sufficient but not necessary criteria to act as guidelines for deciding on the appropriate notification effort was very appealing to the Subcommittee. These sufficient but not necessary criteria would be used by an internal NIOSH committee to review the cohort studies and make a recommendation regarding notification. Superimposed on this structure would be an external committee to audit the decisions of the NIOSH internal committee to ensure appropriate use of the criteria.

F. Media Impact

The role that the media plays in the process of individual worker notification was left unresolved. The incremental benefit contributed by the media is a question that may warrant further attention. Based on the experience in Augusta, where individual workers were notified by the media prior to receiving the NIOSH letters, it is conceivable that the NIOSH proposed decision logic may in fact not be used for notifying individual workers but to notify the media. Whatever the case, it is clear that a close, cooperative, working relationship must be established with the media to maximize effectiveness and minimize distortion.

TABLE OF INDIVIDUAL WORKER NOTIFICATION OPTIONS

Option 1	Option 2	Option 3
If attributable risk $\leq$25%, or SMR $\geq$133, and absolute risk $<10^{-3}$,	If attributable risk >25% and <50%, or SMR >133 and <200, and absolute risk $>10^{-3}$ and $<10^{-5}$,	If attributable risk $\geq$50%, or SMR >200, and absolute risk $>10^{-3}$,
Then:	Then:	Then:
1. The cohort should be notified through information on the study being provided to the involved company and union officials, and where appropriate, posting of the report in the involved locations.	1. Notify the involved industry and unions as outlined in Option 1.	1. Locate individual members of the cohort.
2. Employers and union representatives for the same type of industries should be notified of the results through a general notification effort.	2. NIOSH Alert: Through appropriate mechanisms such as a Hazard Alert, NIOSH should take active steps to notify the industry and work force of the hazard.	2. Send individual letters of notification to the cohort participants informing them of their assumed increased risk.
	3. Notify the local newspapers and media in the areas where the cohort is located of the findings of the study and the implication of these findings for the study participants.	3. Notification of noncohort workers as outlined in Option 2.
	4. Notify the appropriate public health agencies.	4. Appropriate provision for workers to contact NIOSH personnel to obtain further information.

APPENDIX 1

MEMBERS AND CONSULTANTS TO THE SUBCOMMITTEE ON INDIVIDUAL WORKER NOTIFICATION

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APPENDIX 2

Examples of the Application of the Guidelines to Four Studies

Waxweiler, R. J., et al: Neoplastic Risk Among Workers Exposed to Vinyl Chloride. Ann NY Acad Sci 271:40-48, 1976.

Abstract

The health effects of occupational exposure to vinyl chloride were evaluated in a cohort of 1294 workers at four polymerization plants. Analysis of 136 deaths showed statistically significant SMRs of 149 for all malignant neoplasms and 1155 for biliary and liver cancer. For workers with more than 15 years since onset of exposure, statistically significant SMRs occurred for all malignant neoplasms 184, brain and CNS cancer 498, respiratory system cancer 194, and biliary cancer 1601. Eleven of 14 biliary and liver cancers were angiosarcomas.

Analysis

A. The study is appropriately designed and analyzed.

B. The findings are consistent with other studies.

C. The cohort has not been extensively notified.

D. The SMR for liver cancer is considerably in excess of 300, the attributable risk percent is greater than 50 percent, and the absolute risk is of the order of 10^{-3}; therefore, individual worker notification of this cohort would be warranted. Also found in excess and thus eligible for notification though of lower priority were cancers of the brain, respiratory system and lymphatic system.

Stern, F. B., et al: Exposure of Motor Vehicle Examiners to Carbon Monoxide: A Historical Prospective Mortality Study. Arch Environ Health 36(2): 59-65, March-April, 1981.

Abstract

The National Institute for Occupational Safety and Health (NIOSH) investigated the health effects of chronic exposure to low concentrations of carbon monoxide by conducting a historical prospective cohort study of mortality patterns among 1,558 white male motor vehicle examiners who were employed in New Jersey for a minimum of 6 months between 1944 and 1973. Industrial hygiene surveys indicated that the examiners were exposed to carbon monoxide at a time-weighted average (TWA) of 10-24 ppm; the exposure level recommended by NIOSH is 35 ppm TWA. A modified life table technique was used to calculate cause-specific expected deaths for the cohort adjusted for age and calendar time periods. The expected deaths were compared to the number of observed deaths through August 1973. The cohort demonstrated a slight overall increase in cardiovascular disease deaths (124 observed vs. 118.4 expected), but a more pronounced excess was observed within the first 10 year following employment (28 observed vs. 20.9 expected). A statistically significant excess of cancer mortality was found for motor vehicle examiners after 30 year latency (13 observed vs. 6.9 expected, $P < .05$); this excess, however, was not confined to any particular organ site. The number of deaths due to accidents was significantly lower than expected (8 observed vs. 19.6 expected, $P < .01$).

Analysis

A. The study is appropriately designed and analyzed.

B. The findings of an increased attributable risk percent for brain cancer (60 percent) and SMR of 253 would seem to qualify this cohort for notification. However, this finding is not substantiated by other sources and therefore would not warrant individual notification without further study. The same is true for cancer of the pharynx which in this study analysis shows a SMR of 251 and an attributable risk percent of 60 percent.

C. This cohort has not been extensively notified.

D. A review of study results, taken in context with existing research, indicates that further study is needed before a decision for individual notification can be based on the application of suggested criteria.

Robinson, C., et al: Mortality pattern of rock and slag mineral wool production workers. Br. J Ind Med 39:45-53, 1982

Abstract

An epidemiologic and environmental study of rock and slag mineral wool production was undertaken at a plant that has been in operation since the early 1900's. Size characteristics of fibers produced by each process at the plant and industrial hygiene surveys were used to evaluate current and past exposures. These data suggest that the average historical airborne fiber concentration probably did not exceed 2.5 fiber/cc and 1.0 fiber/cc after 1935. A retrospective cohort mortality study was designed to assess mortality patterns. Detailed occupational histories were compiled on all plant employees. All jobs in the plant were assigned to one of eight exposure categories to assess the extent and severity of mineral wool exposure and the effect of other significant exposure on employee mortality. Findings included an increase in the number of deaths due to cancer of the digestive system and non-malignant respiratory disease among workers who had over 20 years' since their first exposure to mineral wool. These findings are not inconsistent with those of Enterline's (Symposium on Biological Effects of Mineral Fibers, Lyon, France, September 1979) in the Thermal Insulation Manufacturers' Association's mortality study of men employed in four mineral wool plants

Analysis

A. The study is an appropriately designed and analyzed epidemiologic study when reviewed within the context and definition of the "Guidelines for Notification of Individual Workers". The cohort, as described, was adequately defined. The data collection and analysis was performed in a manner consistent with accepted epidemiologic practices.

B. These findings are consistent with those of other studies.

C. Survivors continue to be at risk.

D. This cohort has not been extensively notified.

E. The SMR for respiratory disease is 167 with an attributable risk per cent of 40% which would indicate eligibility for individual worker notification through the industry, unions, local media with appropriate public health agencies also being notified. The SMR for cancer of the digestive system is 130 with an attributable risk per cent of 23% which in itself would not trigger a notification effort. However, since both the SMR and the attributable risk are borderline for Option 1 this study would merit careful consideration.

Lemen et al: Cancer Mortality Among Cadmium Production Workers. Ann NY Acad of Sci, 271:273-279, 1976.

Abstract

A study of 292 white male workers at a cadmium smelter was performed to determine their mortality experience. The results of this epidemiologic study show significantly increased mortality due to total malignancies, lung cancer, and prostatic cancer among cadmium smelter workers. These conservative cause-specific results confirm the findings of previous occupational studies and certainly implicate cadmium exposure as the cause of certain type of malignant disease. This finding, in light of the ubiquitous nature of cadmium in our environment, definitely indicates the need for further research and precautionary efforts to reduce environmental exposures to this metal and its compounds.

Analysis

A. The study is an appropriately designed and analyzed epidemiologic study when reviewed within the context and definition of the "Guidelines for Notification of Individual Workers". The cohort, as described, was adequately defined, of sufficient size, and received reasonable follow-up. The data collection was performed in the usual, customary and reasonable manner for such studies and data analysis appropriate.

B. These findings are consistent with findings from earlier studies, as well as, animal studies. However, a recent detailed update found that workers are at risk of lung cancer but not prostate cancer.

C. Survivors continue to be at risk.

D. This cohort has not been extensively notified.

E. The SMR for cancer of the prostate is 347 with an attributable risk per cent of 59% therefore, individual worker notification of this cohort would entail location of cohort members, letters to individuals informing them of their increased risk, as well as industry and union involvement and general media education for noncohort workers.

APPENDIX 3

Minority Opinions

INTERNATIONAL UNION, UNITED AUTOMOBILE, AEROSPACE & AGRICULTURAL IMPLEMENT WORKERS OF AMERICA—UAW

OWEN F. BIEBER, *PRESIDENT* RAYMOND E. MAJERUS, *SECRETARY-TREASURER*

VICE PRESIDENTS

BILL CASSTEVENS • DONALD F EPHLIN • ODESSA KOMER • MARC STEPP • ROBERT WHITE • STEPHEN P YOKICH

November 25, 1985

Elliot Harris, Ph.D.
National Institute for Occupational
Safety and Health
Building 1, Room 3007
Centers for Disease Control
Atlanta, Georgia 30333

Dear Dr. Harris:

I have reviewed the draft report of the Subcommittee on Individual Worker Notification, dated November 15, 1985, and offer the following comments.

I continue to believe that NIOSH should make an organized effort to notify all surviving workers included in mortality study cohorts of the results of these studies. Notification should in all cases be individual, although other supplemental methods should be included in a program in order to assure effective communication. Notification of results should be provided to workers included in all investigations judged to be appropriately designed and analyzed and should not be dependent upon study results.

My views on this matter rest upon the premise that notification of results and notification of risks are related but separate issues. Once it has been determined that a study was competently performed, all cohort members should be equally entitled to the results as an expression of fundamental civil rights in the workplace. The importance and value of these results to individuals should not be prejudged. Having made a threshold decision to notify workers of study results, NIOSH should then make second order decisions about the content of the communication, including judgments or conclusions about risk. The use of decision guidelines (or decision logic) similar to those on pages six and seven of the draft document would be appropriate at this second stage to determine the exact nature, intensity and content of the notification message to various groups. These guidelines would require modification if the principle of universal individual notification were established.

My remaining points are relatively minor compared with the above:

I think the decision rules on pages six and seven are logically flawed such that certain study groups would completely escape attention. For example, groups with small relative risks (e.g. SMR = 125) but large baseline rates (e.g. cardiovascular disease or lung cancer) would not be placed in any of the notification groups although the public health impact of such risk is considerable.

The guidelines should allow for other measures of risk such as PMRs or MORs.

The draft does not distinguish adequately between the roles and responsibility of employers and unions.

Stronger provisions are necessary regarding environmental intervention, medical services and related risk management activities with respect to the groups felt to be at highest risk.

In summary, I do not find the current draft acceptable, although I believe it to be a substantial improvement of the original working document provided to the subcommittee. I hope that additional discussion will move the consultants and subcommittee members closer to consensus and will eliminate the necessity for minority statements to accompany the final report to the Board of Scientific Counselors.

Sincerely,

Michael A. Silverstein, M.D.
Occupational Health Physician
Health and Safety Department
International Union, UAW

MAS:mb
opeiu494

cc: Warren Winkelstein, Jr., M.D.

UNIVERSITY OF CALIFORNIA, LOS ANGELES UCLA

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SCHOOL OF PUBLIC HEALTH
LOS ANGELES, CALIFORNIA 90024

December 3, 1985

P. Craig Whiters, Jr.
Program Analyst
NIOSH
Centers for Disease Control
Atlanta, GA 30333

Dear Mr. Whithers,

I have some important concerns about the revised report of the Subcommittee on Individual Worker Notification which, by the way, I find substantially improved.

The major concern is one which relates to the decision guidelines as such. The "cut points" in section E. 1-3, as laid out on pages six and seven, are much too high. I would appreciate some further discussion on this matter but my first proposal would be to reduce the attributable risk percents in all three sections. In the first section I would use 10 instead of 25, in the second 10-20 in stead of 25 to 50 and in the third I would use 20%. The problem is that it would seem to me important to notify a working group of the population risks of a disease if ten percent of it could be attributed to the workplace.

The problem with the application of these guidelines to the examples is also of some concern. In example two the attributable risk percents of 60% and the SMR s of 253 and 251 are concluded not to meet the guidelines because of lack of substantiation. I have not reviewed the information but the supporting documentation does not indicate how much effort was spent looking for substantiation (i.e. more than replication of the findings) and whether the findings are biologically plausible even without replication. I understand that the example was not expected to be an extensive discussion but it would be desirable to know how these guidelines would actually be applied. The proposed oversight function of an external advisory committee would serve a function here (although it too would need more substantial report of the evaluation).

A similar concern is present in example three where SMR and attributable risk percent just under the guidelines is eliminated from consideration because "in itself (it) would not trigger a notification effort". Although literally correct it suggests a problem with rigid application of guidelines. Again, I understand that the NIOSH staff did not intend this to be an extensive discussion of the example but the issues raised by

these examples are much more complex than were discussed at the first subcommittee meeting. I believe that the guidelines would benefit from further discussion of these examples to clarify how such a system could actually work.

I have several other and more specific comments which I have described, in the following pages, with specific reference to the location in the text of the draft meeting report.

Page 4.

The last sentence in the first paragraph refers to conclusions about the applicability of the Augusta study to individuals. I don't remember this disucssion nor how it was judged applicable.

Page 5. Section A.2.

This could be rewritten to say "Was the study population appropriate and of sufficient size to address this hypothesis?"

Page 5. Section A.3.

Add "length of" after "...to both the"

Page 5. Section B.

The last sentence is unclear. Do you mean to say "...much greater evidence of elevated risk..." or "...evidence of much greater risk..." or both?

Page 6. Section C.

I suggest adding the words "unique or" between "the plant with" and "much greater" in the fifth line of the second paragraph on the page.

Page 6. Section D.

I suggest replacing the words "would be needed" with the words "is proposed" in the fifth line.

Page 7. Section E.1.

The intervals, as listed in subsection 1. are not inclusive. I believe the parenthetical statement should read (or the SMR is no greater than 133).

Page 7. Section E.1.b.

I suggest replacing the word "appropriate" with the word "possible" in the fourth line.

Page 7. Section E.2.a.

I have some problem with the language which refers to notify the involved "industry". We have been reviewing the OSHA MIS data on compliance with standards and find an extremely large number of industries (categorized by four digit SIC) which have excessive exposure to lead. It is not clear to me that "industry" would be the best identifier of the key concerns. It might be based on users or user associations or some other measure which reduces the number of units receiving the notificaiton to just those who need it.

Page 7. Section E.2.

I am surprised that none of us picked up on an obvious omission from this list. I suggest we add a section: "e. Notify local and state health departments and labor departments".

Page 7. Section E.

The final paragraph of this section states a conclusion which I know was of concern to the NIOSH staff but I believe was not agreed to by the subcommittee. This is not to say that support services are not important but just that their "thorough evaluation before proceeding" was not a conclusion of the meeting.

Page 7. Section F.1.

The statement is correct but it is not suggested how the review process would or could deal with the problem as stated.

Page 8. Section F.3.

I suggest replacing the words "may not be" with the words "is probably not"

Page 9. Section F.4.

I suggest adding to the sentence the phrase: "and only if the unadjusted estimates of probability are also presented".

Page 10 Section B.

I recommend eliminating the last sentence except for the last phrase: "No recommendation for minimum notification was made."

Page 10 Section C.

The word "applying" should be "apply". I would also suggest adding the phrase "to development of public health knowledge and" between the words "contributing to" and "the Federal government's standards" in the fourth line.

Page 10 Section C.2.

I suggest striking the word "statistical".

Page 10 Section D.

What is meant by the word "sequential" in the third line? Also, from this point forth the words "decision logic" are used when we agreed to the term "guidelines".

Page 11 Section F.

I suggest that the word "when" be replaced by the word "where" in the fourth line.

I hope you find these comments useful. I would prefer to have further discussion on several of these points before the report is presented to the Board of Scientific Counselors. Please let me know what further help you need from me.

Sincerely,

cc: Warren Winkelstein

David H. Wegman, M.D.
Professor and Division Head
Environmental and Occupational
Health Sciences

Dr. MELIUS. We will. That report is from our Board of Scientific Counselors, providing us advice on the best approaches for a decision logic to choose among our retrospective cohort mortality studies. I think it is important to point out that this report will not cover the vast majority of workers being considered under this bill. For many of these workers, we do not have epidemiologic studies that define their risk. All we have is some information that they may or may not be exposed in the workplace.

Senator METZENBAUM. Dr. Melius, this is my last question. Are you satisfied with the worker notification programs which are currently in effect in this country?

Dr. MELIUS. I believe we have a start within our own institute on being able to appropriately notify the workers in our own studies. I think we have also taken steps with the Hazard Communication Standards to get information to other workers.

Senator METZENBAUM. I guess that is not really my question. You say you have made a start. I am asking you, as one who is head of the——

How long have you been head of the division of surveillance, hazard evaluation and field studies?

Dr. MELIUS. Approximately 1 year.

Senator METZENBAUM. My question to you is, Are you satisfied, on a scale of 1 to 10, would you indicate whether you personally are satisifed that enough is being done?

Dr. MELIUS. If the question is, is there more that could be done, the answer would be yes; there are groups that do warrant notification.

Senator METZENBAUM. Thank you very much.

Senator NICKLES. Senator Metzenbaum, thank you very much.

Senator Kennedy, do you have questions?

Senator KENNEDY. Yes, just briefly, Mr. Chairman. I hope you gentlemen understand some of the frustration that many of us have who have been strongly in support of trying to ensure adequate protections for those who are in the workplaces of this country. We had the promulgation of a policy over 8 years ago, in terms of the basic questions of the right to know, and that was during the previous administration. The actual implementation or regulations, as I understand, will go into effect 2 weeks from now. Am I correct on that?

Mr. TYSON. Two totally separate standards, Senator, two totally separate issues.

Senator KENNEDY. Well, then, correct me on that.

Mr. TYSON. The first reference you make is something called the Access to Medical Records and Exposure Monitoring Standard, which was promulgated to ensure that employees would have access to any information in the employer's possession with respect to their exposure to toxic substances or to the types of substances they were exposed to, or any medical records that were done.

Senator KENNEDY. OK. Now, when was that?

Mr. TYSON. That was done, I think, in 1978.

Senator KENNEDY. OK. Has that been done?

Mr. TYSON. That has been in full effect since.

Senator KENNEDY. Since 1978?

Mr. TYSON. Yes, sir. [The Access Standard was proposed in July 1978, issued in May 1980, and became effected in August 1980.]

The standard that we are talking about today that goes into effect in 2 weeks, May 25, the Hazard Communication Standard, requires an affirmative action by employers to evaluate every substance which is introduced into that workplace to assure that there are no hazardous effects associated with it. If there are hazardous effects, that information has to be made available to employees through the form of material safety data sheets, labeling for the containers that these products would be in, and a training program that will specifically tell employees what the whole system means and how to protect themselves. It will produce an incredible wealth of information. Never before, never before, has there been anything approaching this in terms of this level of information on the toxic effects of various substances. We are talking about over a half million different substances.

Senator KENNEDY. Now, does the medical access standard guarantee the employees will see their exposure and medical records?

Mr. TYSON. Absolutely, within a very short timeframe and free-of-cost.

Senator KENNEDY. And does the access standard entitle employees to a medical exam at all?

Mr. TYSON. The specific provisions in OSHA's Comprehensive Health Standards, the 20 standards that we talked about earlier, all have provisions that require medical surveillance and testing, again at no cost to the employee, and employees will have access to that information.

Any future health standard that OSHA promulgates will also have to include provisions for medical surveillance and testing.

Senator KENNEDY. That is one of the basic issues at conflict; one is access, and one is being informed. I mean, that is one of the basic and fundamental differences in approach. As I understand, even with the promulgation of regulations, there is some disparity about what percent of the workers who are actually exposed to the various toxic substances are going to even have access if they want information. We hear varying percentages on that. I used the figure 30 to 40 percent, which has been estimated.

So we are leaving a major segment of the population who are exposed to it to these problems; they are excluded.

Mr. TYSON. I would quarrel with that figure.

Senator KENNEDY. You would? What would you estimate?

Mr. TYSON. The Medical Access Standard is applicable to every employer in this country, and every employee under that standard has the ability and has the right to the information in that employer's files on their exposure and on their medical records and to the substances they were exposed to.

Senator KENNEDY. Does that apply to growers who are employing field workers, to farm workers?

Mr. TYSON. Yes; to the extent that we are not limited by an appropriations rider passed by Congress.

[Information supplied for the record follows:]

OSHA's Standard for Access to Medical Records and Exposure Monitoring would apply to growers' employees who work in warehouses and packaging facilities, but not to agricultural laborers. OSHA's safety and health standards for Agriculture (29

CFR Part 1928) specifically exclude the application of all but six OSHA standards to agricultural operations. These are the standards for: roll-over protective structures for tractors; guarding of farm field equipment, farmstead equipment, and cotton gins; temporary labor camps; storage and handling of anhydrous ammonia; pulpwood logging; and slow-moving vehicles. None of OSHA's other standards applies to agricultural operations.

Senator KENNEDY. So it applies to all the growers out in Texas, in California, and in Florida. So the farm workers will be able to find out what danger they have in terms of the increase, the disparity in infant mortality, and the problems they are having in terms of childbearing and the problems they are having——

Mr. TYSON. Related to a substance.

Senator KENNEDY. If they believe that that is related to a substance, then they can go to the growers, and the growers will be required to keep on file medical information that they will be able to have access to.

Mr. TYSON. Any medical tests that were given; that record has to be maintained for 30 years beyond the employment of that individual; any exposure information with respect to studies that were done on what level of exposure employees were exposed to has to be maintained.

Senator KENNEDY. What information are they going to be required to keep? Is it just medical tests?

Mr. TYSON. Medical testing results. Exposure monitoring results, if they did exposure monitoring in the workplace——

Senator KENNEDY. Well, what if they do not do it because they are not required to do it? Are they required to do it?

Mr. TYSON. They are not required under many standards. They are required under the 20 comprehensive health standards.

Senator KENNEDY. All right. Well, then, what percent of the workplaces are covered by the 20? That does not cover all. That is where we get down to the disparity and how many are going to actually be covered.

Mr. TYSON. For those health standards, every worker exposed to any of those substances is covered.

Senator KENNEDY. And there are dangers on other substances that are not included in that.

Mr. TYSON. That is absolutely correct.

Senator KENNEDY. Now, what amount in terms of the workers are covered——

Mr. TYSON. That is where the hazard communication standard comes into play because there, rather than try to deal with this issue on a substance-by-substance approach, which is a very time-consuming kind of affair, because you have to go through all the process of the Administrative Procedure Act to promulgate any regulation—hazard communication requires that the information be made available on any substance which is shown to cause a health hazard. And we are talking here about 14 million employees, starting in 2 weeks, that are going to have access to that information, have to be trained on what it means and how to protect themselves.

Senator KENNEDY. Well, that is 14 million that will have access. We do not know how many are actually going to be able to pursue its availability, accessibility, and that point has been reviewed by

others here. Access certainly is a good deal different from actual notification. You are talking about 14 million.

Mr. TYSON. Again, if I could correct you, Senator, the hazard communication standard requires more than just access to this information. It requires that an employee be trained on the hazards that they are going to have in their workplace, the substances that are going to be introduced, what the label means, and what the material safety data sheet means before they are exposed to that substance for the first time.

Senator KENNEDY. Well, the last employment figures indicate approximately 86 million other Americans who are not covered by any of these regulations.

Mr. TYSON. The 14 million number that I refer to are all employees within the manufacturing sector where the standard has direct application. There will be many, many more employees who will get the downstream effect of that, because the material safety data sheets will go into other segments of the economy. There is no question that that will happen. And then the medical access standard that we referred to earlier takes effect, and that guarantees the access to that material safety data sheet for employees in those other sectors.

Senator KENNEDY. That is assuming that they ask, and they have sufficient information for them.

Mr. TYSON. They are required to be notified of the right that they can ask.

Senator KENNEDY. But not each individual.

Mr. TYSON. As part of the posting requirement under the standard.

Senator KENNEDY. Posting.

What is your estimate—we hear that about 440,000—it is difficult, obviously, to get to an absolute mathematical certainty—are exposed; about 100,000 die a year in terms of various toxic substances. In the review of the agency, how is that figure going to be changed, do you believe, by these?

Mr. TYSON. Senator, I believe the hazard communication standard which, as I mentioned earlier, goes into effect in 2 weeks, is the most significant regulatory action ever taken by OSHA and probably any other health-related agency. It is going to provide such information out there as to the toxic effects of substances, that I think that the number of employees who in future generations and future years are going to suffer from occupationally induced disease is going to be very dramatically reduced.

Senator KENNEDY. During the consideration of the regulations, did any numbers ever come forward?

Mr. TYSON. Well, there is a serious problem with the counting of what diseases are in fact occupationally induced. We have known for many years that we do not have good data on what the real picture is in this country as to the incidence of disease which can be directly related to workplace exposure. We can see that with certain substances such as asbestos, where you have a very clear disease that is associated with exposure to a specific substance. We can see it with things like cotton dust, where you have bisonosis. You only get bisonosis from exposure to cotton dust.

Senator KENNEDY. Lead.

Mr. TYSON. Lead, lead poisoning again, a good example, Senator.

There are many, many more substances in use in the workplace which have carcinogenic effects. Cancers such as lung cancer, there is a very significant background of lung cancer in this country already, some 7 per 1,000. Any increase in that, it is hard to show any relationship to a specific exposure, because any number of exposures could trigger that increase.

So the data on occupational illnesses in this country, I think all health professionals will admit, is very poor.

Senator KENNEDY. I will submit other questions.

I just want to acknowledge your service, Mr. Tyson.

Mr. TYSON. Thank you, Senator. Thank you very much.

Senator KENNEDY. So often those who serve in some of these agencies, their contributions are overlooked. And I think we all recognize that you have done a workmanlike job in the responsibility—I am sure the others have, too, but you are not leaving. We will have a chance to see at another time. [Laughter.]

Mr. TYSON. Senator Kennedy, thank you very much.

Senator NICKLES. Senator Kennedy, I would echo those comments, as I did earlier. To our other panelists, if you come up before the committee on your last day of service, you will find out that we were probably planning on asking several questions for the record. As we realize you are going to be gone, we will make an endeavor to get some of the information out before you take off.

Let me just ask a couple of followups, because I think Senator Kennedy was on the fringe of a very important issue. The hazardous communication standard goes into effect in 10 days. That requires all importers and manufacturers of these substances to provide what?

Mr. TYSON. First, to evaluate those substances to determine whether or not there are hazards associated with employee exposure to them. If in fact there are hazards found—and A that evaluation, I should add, is a very specific evaluation—if there is one positive, scientifically—based study, that shows that there is an adverse health effect associated with exposure to a substance, that triggers a whole train of events, starting with the material safety data sheet——

Senator NICKLES. Do you have a copy of that?

Mr. TYSON. I have the material safety data sheet here on lead; I would be happy to introduce it for the record.

Senator NICKLES. Would you submit that in the record so we can have an idea of what that entails?

Mr. TYSON. Yes. I think you will be impressed by the level of detail that these material safety data sheets have to contain on the toxic effects and the long-term toxic effects of substances.

[The material safety data sheet follows:]

62-211 O - 86 - 4

** 806 **

ONS12510 PAGE 01 OF 06

MATERIAL SAFETY DATA SHEET

OCCUPATIONAL HEALTH SERVICES, INC.
400 PLAZA DRIVE
HARMON MEADOWS
SECAUCUS, NJ 07094
1-800-225-8976

EMERGENCY CONTACT:
JOHN S. BRADFORD, JR. (615)292-1180

SUBSTANCE IDENTIFICATION

SUBSTANCE: LEAD

CAS-NUMBER 7439-92-1

TRADE NAMES/SYNONYMS: WHITE LEAD; C.I. PIGMENT METAL 4; C.I. 77575; LEAD FLAKE; KS-4; LEAD 82; 81; 80; PLUMBUM; 51; PB-S 100; GLOVER; OMAHA; OMAHA & GRANT; ONS12510

CHEMICAL FAMILY:
INORGANIC METAL

MOLECULAR FORMULA: PB MOL WT: 207.19

CERCLA RATINGS (SCALE 0-3): HEALTH=3 FIRE=0 REACTIVITY=0 PERSISTENCE=3
NFPA RATINGS (SCALE 0-4): HEALTH=3 FIRE=0 REACTIVITY=0

COMPONENTS AND CONTAMINANTS

PERCENT: 99.8 COMPONENT: LEAD

OTHER CONTAMINANTS: BISMUTH, COPPER, ARSENIC, ANTIMONY, TIN, IRON, SILVER, ZINC

EXPOSURE LIMITS:
0.05 MG/M3 OSHA TWA
0.15 MG/M3 ACGIH TWA (DUST,FUMES); 0.45 MG(PB)/M3 ACGIH STEL (DUST, FUMES)
(NOTICE OF INTENDED CHANGES 1984-85)
0.10 MG/M3 NIOSH RECOMMENDED CEILING

PHYSICAL DATA

DESCRIPTION: BLUISH-WHITE, SILVERY GRAY, HEAVY, MALLEABLE METAL

BOILING POINT: 3164 F (1740 C) MELTING POINT: 622 F (328 C)

SPECIFIC GRAVITY: 11.3 VAPOR PRESSURE: 1.3 MMHG @ 970 C

SOLUBILITY IN WATER: INSOLUBLE SOLVENT SOLUBILITY: HNO3, HOT CONC H2SO4

FIRE AND EXPLOSION DATA

FIRE AND EXPLOSION HAZARD:
NEGLIGIBLE FIRE HAZARD WHEN EXPOSED TO HEAT OR FLAME.

** FO6 **

ON812510 PAGE 02 OF 06

FIREFIGHTING MEDIA:
DRY CHEMICAL, CARBON DIOXIDE, WATER SPRAY OR FOAM
(1984 EMERGENCY RESPONSE GUIDEBOOK, DOT P 5800.3).

FOR LARGER FIRES, USE WATER SPRAY, FOG OR ALCOHOL FOAM
(1984 EMERGENCY RESPONSE GUIDEBOOK, DOT P 5800.3).

FIREFIGHTING:
NO ACUTE HAZARD. MOVE CONTAINER FROM FIRE AREA IF POSSIBLE. AVOID BREATHING VAPORS OR DUSTS; KEEP UPWIND.

USE AGENTS SUITABLE FOR TYPE OF SURROUNDING FIRE. AVOID BREATHING HAZARDOUS VAPORS, KEEP UPWIND (BUREAU OF EXPLOSIVES, EMERGENCY HANDLING OF HAZARDOUS MATERIALS IN SURFACE TRANSPORTATION, 1981).

TOXICITY

450 MG/KG/6 YEAR ORAL-WOMAN TDLO; 10 UG/M3 INHALATION-HUMAN TCLO; 1000 MG/KG INTRAPERITONEAL-RAT LDLO; 160 MG/KG ORAL-PIGEON LDLO; MUTAGENIC DATA (RTEC); REPRODUCTIVE EFFECTS DATA (RTEC); INDEFINITE ANIMAL CARCINOGEN (IARC); INDEFINITE HUMAN CARCINOGEN (IARC).

LEAD IS A NEUROTOXIN, NEPHROTOXIN AND TERATOGEN, AND A CUMULATIVE POISON WHICH MAY ALSO AFFECT THE BLOOD, HEART, ENDOCRINE AND IMMUNE SYSTEMS. DUST OR FUMES MAY IRRITATE THE EYES, SKIN, AND MUCOUS MEMBRANES.

HEALTH EFFECTS AND FIRST AID

INHALATION:
NEUROTOXIN/NEPHROTOXIN/TERATOGEN.

ACUTE EXPOSURE- INHALATION AND SUBSEQUENT ABSORPTION OF LARGE AMOUNTS OF LEAD MAY CAUSE THIRST, A METALLIC TASTE, A BURNING SENSATION IN THE MOUTH AND THROAT, EXCESSIVE SALIVATION, ABDOMINAL PAIN WITH SEVERE COLIC, VOMITING, DIARRHEA OF BLACK OR BLOODY STOOLS, CONSTIPATION, FATIGUE, SLEEP DISTURBANCES, DULLNESS, RESTLESSNESS, IRRITABILITY, MEMORY LOSS, LOSS OF CONCENTRATION, DELIRIUM, OLIGURIA OFTEN WITH HEMATURIA AND ALBUMINURIA, ENCEPHALOPATHY WITH VISUAL FAILURE, PARESTHESIAS, MUSCLE PAIN AND WEAKNESS, CONVULSIONS, AND PARALYSIS. DEATH MAY RESULT FROM CARDIORESPIRATORY ARREST, COMA, OR DEHYDRATION FROM FLUID LOSS AND SHOCK WHICH MAY BE DELAYED FOR 1-2 DAYS. SURVIVAL FROM ACUTE EXPOSURE MAY RESULT IN THE ONSET OF CHRONIC INTOXICATION. LIVER DAMAGE MAY INCLUDE ENLARGEMENT AND TENDERNESS, ICTERUS, AND JAUNDICE. THE APPROXIMATE FATAL DOSE OF ABSORBED LEAD IS APPROXIMATELY 0.5 GRAMS. PATHOLOGIC FINDINGS FROM ACUTE POISONING INCLUDE GASTROINTESTINAL INFLAMMATION AND RENAL TUBULAR DEGENERATION.

CHRONIC EXPOSURE- PROLONGED OR REPEATED EXPOSURE TO LOW LEVELS OF LEAD MAY RESULT IN AN ACCUMULATION IN BODY TISSUES AND EXERT ADVERSE EFFECTS ON THE BLOOD, NERVOUS SYSTEMS, HEART, ENDOCRINE AND IMMUNE SYSTEMS, KIDNEYS, AND REPRODUCTION. EARLY STAGES OF LEAD POISONING, "PLUMBISM", MAY BE EVIDENCED BY ANOREXIA, WEIGHT LOSS, CONSTIPATION, APATHY OR IRRITABILITY, OCCASIONAL VOMITING, FATIGUE, HEADACHE, WEAKNESS, METALLIC TASTE IN THE MOUTH, GINGIVAL LEAD LINE IN PERSONS WITH POOR DENTAL HYGIENE, AND ANEMIA. LOSS OF RECENTLY DEVELOPED MOTOR SKILLS IS GENERALLY OBSERVED ONLY IN CHILDREN. MORE ADVANCED STAGES OF POISONING MAY BE CHARACTERIZED BY INTERMITTENT VOMITING, IRRITABILITY AND NERVOUSNESS, MYALGIA OF THE ARMS, LEGS, JOINTS

AND ABDOMEN, PARALYSIS OF THE EXTENSOR MUSCLES OF THE ARMS AND LEGS WITH WRIST AND/OR FOOT DROP. DISTURBANCES OF MENSTRUAL CYCLES AND SPONTANEOUS ABORTIONS MAY OCCUR IN WOMEN. SEVERE "PLUMBISM" MAY RESULT IN PERSISTENT VOMITING, ATAXIA, PERIODS OF STUPOR OR LETHARGY, ENCEPHALOPATHY WITH VISUAL DISTURBANCES WHICH MAY PROGRESS TO OPTIC NEURITIS AND ATROPHY, HYPERTENSION, PAPILLEDEMA, CRANIAL NERVE PARALYSIS, DELIRIUM, CONVULSIONS, AND COMA. NEUROLOGIC SEQUELAE MAY INCLUDE MENTAL RETARDATION, SEIZURES, CEREBRAL PALSY, AND DYSTONIA MUSCULORUM DEFORMANS. IRREVERSIBLE KIDNEY DAMAGE HAS BEEN ASSOCIATED WITH INDUSTRIAL EXPOSURE. REPRODUCTIVE EFFECTS HAVE BEEN EXHIBITED IN BOTH MALES AND FEMALES. PATERNAL EFFECTS MAY INCLUDE DECREASED SEX DRIVE, IMPOTENCE, STERILITY AND ADVERSE EFFECTS ON THE SPERM WHICH MAY INCREASE THE RISK OF BIRTH DEFECTS. MATERNAL EFFECTS MAY INCLUDE MISCARRIAGE AND STILLBIRTHS IN EXPOSED WOMEN OR WOMEN WHOSE HUSBANDS WERE EXPOSED, ABORTION, STERILITY OR DECREASED FERTILITY, AND ABNORMAL MENSTRUAL CYCLES. LEAD CROSSES THE PLACENTA AND MAY AFFECT THE FETUS CAUSING BIRTH DEFECTS, MENTAL RETARDATION, BEHAVIORAL DISORDERS, AND DEATH DURING THE FIRST YEAR OF CHILDHOOD. ANIMAL STUDIES INDICATE THAT REPRODUCTIVE EFFECTS MAY BE ADDITIVE IF BOTH PARENTS ARE EXPOSED TO LEAD.

FIRST AID- REMOVE FROM EXPOSURE AREA TO FRESH AIR IMMEDIATELY. IF BREATHING HAS STOPPED, GIVE ARTIFICIAL RESPIRATION. MAINTAIN AIRWAY AND BLOOD PRESSURE AND ADMINISTER OXYGEN IF AVAILABLE. KEEP AFFECTED PERSON WARM AND AT REST. GET MEDICAL ATTENTION. (DREISBACH, HANDBOOK OF POISONING, 11TH ED.)

SKIN CONTACT:

ACUTE EXPOSURE- CONTACT WITH LEAD POWDERS OR DUST MAY BE IRRITATING. LEAD IS NOT ABSORBED THROUGH THE SKIN, BUT MAY BE TRANSFERRED TO THE MOUTH INADVERTENTLY BY CIGARETTES, CHEWING TOBACCO, FOOD, OR MAKE-UP.

CHRONIC EXPOSURE- PROLONGED OR REPEATED EXPOSURE TO THE POWDER OR DUST MAY RESULT IN DERMATITIS. SYSTEMIC TOXICITY MAY DEVELOP IF LEAD IS TRANFERRED TO THE MOUTH BY CIGARETTES, CHEWING TOBACCO, FOOD, OR MAKE-UP.

FIRST AID- REMOVE CONTAMINATED CLOTHING AND SHOES IMMEDIATELY. WASH AFFECTED AREA WITH SOAP OR MILD DETERGENT AND LARGE AMOUNTS OF WATER (APPROXIMATELY 15-20 MINUTES) UNTIL NO EVIDENCE OF CHEMICAL REMAINS.

EYE CONTACT:

ACUTE EXPOSURE- LEAD DUST OR POWDERS MAY BE IRRITATING. METALLIC LEAD PARTICLES MAY CAUSE AN INFLAMMATORY FOREIGN BODY REACTION AND INJURY IS GENERALLY THOUGHT TO BE MECHANICAL AND NOT TOXIC.

CHRONIC EXPOSURE- PROLONGED EXPOSURE MAY CAUSE CONJUNCTIVITIS.

FIRST AID- WASH EYES IMMEDIATELY WITH LARGE AMOUNTS OF WATER, OCCASIONALLY LIFTING UPPER AND LOWER LIDS, UNTIL NO EVIDENCE OF CHEMICAL REMAINS (APPROXIMATELY 15-20 MINUTES). GET MEDICAL ATTENTION.

INGESTION:
NEUROTOXIN/NEPHROTOXIN/TERATOGEN.

ACUTE EXPOSURE- INGESTION AND SUBSEQUENT ABSORPTION OF LARGE AMOUNTS OF LEAD MAY CAUSE THIRST, A METALLIC TASTE, A BURNING SENSATION IN THE MOUTH AND THROAT, EXCESSIVE SALIVATION, ABDOMINAL PAIN WITH SEVERE COLIC, VOMITING, DIARRHEA OF BLACK OR BLOODY STOOLS, CONSTIPATION, FATIGUE, DISTURBANCES OF SLEEP, DULLNESS, RESTLESSNESS, IRRITABILITY, MEMORY LOSS, LOSS OF CONCEN-

TRATION, DELIRIUM, OLIGURIA OFTEN WITH HEMATURIA AND ALBUMINURIA, ENCEPHALOPATHY WITH VISUAL FAILURE, PARESTHESIAS, MUSCLE PAIN AND WEAKNESS, CONVULSIONS, AND PARALYSIS. DEATH MAY RESULT FROM CARDIORESPIRATORY ARREST, COMA, OR DEHYDRATION FROM FLUID LOSS AND SHOCK WHICH MAY BE DELAYED FOR 1-2 DAYS. SURVIVAL FROM ACUTE EXPOSURE MAY RESULT IN THE ONSET OF CHRONIC INTOXICATION. LIVER DAMAGE MAY INCLUDE ENLARGEMENT AND TENDERNESS, ICTERUS, AND JAUNDICE. THE APPROXIMATE FATAL DOSE OF ABSORBED LEAD IS APPROXIMATELY 0.5 GRAMS. PATHOLOGIC FINDINGS FROM ACUTE POISONING INCLUDE GASTROINTESTINAL INFLAMMATION AND RENAL TUBULAR DEGENERATION.

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FIRST AID- DO NOT INDUCE VOMITING. QUALIFIED MEDICAL PERSONNEL SHOULD REMOVE METAL BY GASTRIC LAVAGE OR CATHARSIS. ACTIVIATED CHARCOAL IS USEFUL. GET MEDICAL ATTENTION IMMEDIATELY.

ANTIDOTE:
INITIATE URINE FLOW FIRST. GIVE 10% DEXTROSE IN WATER INTRAVENOUSLY, 10-20 ML/KG BODY WEIGHT, OVER A PERIOD OF 1-2 HOURS. IF URINE DOES NOT START, GIVE MANNITOL, 20% SOLUTION, 5-10 ML/KG BODY WEIGHT INTRAVENOUSLY OVER 20 MINUTES. FLUID MUST BE LIMITED TO REQUIREMENTS, AND CATHETERIZATION MAY BE NECESSARY IN SOME CASES. ANTIDOTE MUST BE ADMINISTERED BY QUALIFIED MEDICAL PERSONNEL.

REACTIVITY

REACTIVITY:
STABLE UNDER NORMAL TEMPERATURES AND PRESSURES.

INCOMPATIBILITIES:
LEAD:

** 807 **

AMMONIUM NITRATE: EXPLOSIVE REACTION.
CHLORINE TRIFLUORIDE: VIOLENT REACTION.
DISODIUM ACETYLIDE: TRITURATION IN MORTAR MAY BE VIOLENT AND LIBERATE CARBON.
HYDROGEN PEROXIDE, 60% TRIOXANE SOLUTION: SPONTANEOUSLY DETONABLE.
NITRIC ACID: LEAD-CONTAINING RUBBER MAY IGNITE.
SODIUM AZIDE: FORMS LEAD AZIDE IN COPPER PIPE.
SODIUM CARBIDE: VIGOROUS REACTION.
SULFURIC ACID (HOT): REACTS.
ZIRCONIUM-LEAD ALLOYS: IGNITION ON IMPACT.

DECOMPOSITION:
THERMAL DECOMPOSITION PRODUCTS ARE TOXIC OXIDES OF LEAD.

POLYMERIZATION:
NONE KNOWN.

****

CONDITIONS TO AVOID

MAY BURN BUT DOES NOT IGNITE READILY.

****

SPILL AND LEAK PROCEDURES

OCCUPATIONAL SPILL:
DO NOT TOUCH SPILLED MATERIAL. STOP LEAK IF YOU CAN DO IT WITHOUT RISK. FOR SMALL SPILLS, TAKE UP WITH SAND OR OTHER ABSORBENT MATERIAL AND PLACE INTO CONTAINERS FOR LATER DISPOSAL. FOR SMALL DRY SPILLS, WITH A CLEAN SHOVEL PLACE MATERIAL INTO CLEAN, DRY CONTAINER AND COVER. MOVE CONTAINERS FROM SPILL AREA. FOR LARGER SPILLS, DIKE FAR AHEAD OF SPILL FOR LATER DISPOSAL. KEEP UNNECESSARY PEOPLE AWAY. ISOLATE HAZARD AREA AND DENY ENTRY.

PROTECTIVE EQUIPMENT

VENTILATION:
PROVIDE LOCAL EXHAUST OR PROCESS ENCLOSURE VENTILATION TO MEET THE PUBLISHED EXPOSURE LIMITS. VENTILATION EQUIPMENT MUST BE EXPLOSION-PROOF.

RESPIRATOR:
THE FOLLOWING RESPIRATORS AND MAXIMUM USE CONCENTRATIONS ARE RECOMMENDATIONS BY NIOSH/OSHA OR 29CFR1910; SUBPART Z.
THE SPECIFIC RESPIRATOR SELECTED MUST BE BASED ON CONTAMINATION LEVELS FOUND IN THE WORK PLACE AND BE JOINTLY APPROVED BY THE NATIONAL INSTITUTE OF OCCUPATIONAL SAFETY AND HEALTH AND THE MINE SAFETY AND HEALTH ADMINISTRATION.

RESPIRATORY PROTECTION FOR LEAD AEROSOLS

AIRBORNE CONCENTRATION OF LEAD OR CONDITION OF USE	REQUIRED RESPIRATOR
NOT IN EXCESS OF 0.5 MG/M3 (10X PEL)	HALF-MASK, AIR PURIFYING RESPIRATOR EQUIPPED WITH HIGH-EFFICIENCY FILTERS.
NOT IN EXCESS OF 2.5 MG/M3 (50X PEL)	FULL FACEPIECE, AIR-PURIFYING RESPIRATOR WITH HIGH EFFICIENCY

	FILTERS.
NOT IN EXCESS OF 50 MG/M3 (1000X PEL)	ANY POWERED AIR-PURIFYING RESPIRATOR WITH HIGH EFFICIENCY FILTERS; OR HALF-MASK SUPPLIED-AIR RESPIRATOR OPERATED IN POSITIVE-PRESSURE MODE.
NOT IN EXCESS OF 100 MG/M3	SUPPLIED-AIR RESPIRATORS WITH FULL FACEPIECE, HOOD OR HELMET OR SUIT, OPERATED IN POSITIVE PRESSURE MODE.
GREATER THAN 100 MG/M3, UNKNOWN CONCENTRATIONS OR FIREFIGHTING	FULL FACEPIECE, SELF-CONTAINED BREATHING APPARATUS OPERATED IN POSITIVE-PRESSURE MODE.

(RESPIRATORS SPECIFIED FOR HIGHER CONCENTRATIONS CAN BE USED AT LOWER CONCENTRATIONS OF LEAD.)
(FULL FACEPIECE IS REQUIRED IF THE LEAD AEROSOLS CAUSE EYE OR SKIN IRRITATION AT THE USE CONCENTRATIONS.)
(A HIGH EFFICIENCY PARTICULATE FILTER MEANS 99.97% EFFICIENT AGAINST 0.3 MICRON PARTICLES.)

FOR FIREFIGHTING AND OTHER IMMEDIATELY DANGEROUS TO LIFE OR HEALTH CONDITIONS:

SELF-CONTAINED BREATHING APPARATUS WITH FULL FACEPIECE OPERATED IN PRESSURE-DEMAND OR OTHER POSITIVE PRESSURE MODE.

SUPPLIED-AIR RESPIRATOR WITH FULL FACEPIECE AND OPERATED IN PRESSURE-DEMAND OR OTHER POSITIVE PRESSURE MODE IN COMBINATION WITH AN AUXILIARY SELF-CONTAINED BREATHING APPARATUS OPERATED IN PRESSURE-DEMAND OR OTHER POSITIVE PRESSURE MODE.

CLOTHING:
PROTECTIVE CLOTHING AND EQUIPMENT MUST COMPLY WITH THE PROVISIONS OF 29CFR1910.1025(G).

GLOVES:
PROTECTIVE GLOVES AND EQUIPMENT MUST COMPLY WITH THE PROVISIONS OF 29CFR1910.1025(G).

EYE PROTECTION:
EMPLOYEE MUST WEAR SPLASH-PROOF OR DUST-RESISTANT SAFETY GOGGLES TO PREVENT EYE CONTACT WITH THIS SUBSTANCE.

AUTHORIZED - OCCUPATIONAL HEALTH SERVICES, INC.
CREATION DATE: 12/10/84 REVISION DATE: 03/26/86

Senator NICKLES. Now, to get into the practical effects. You are telling a manufacturer or a chemical company that happens to have lead in their substance or their application, to include that information. I want to get into Senator Kennedy's question—is this going to get out and reach the bulk of the workplace in America. Let us say XYZ Chemical Co. has that, and they use it, and they know these studies have already been done, and that is already history. You have that material safety data sheet that is supplied. Does that also require a whole variety of companies they happen to be selling that chemical to to notify their workers and train them? What steps or precautions are necessary to prevent any type of occupational disease?

Mr. TYSON. Absolutely. Let me walk you through it, just quickly. I realize that you are short of time. But on November 25 of last year, this standard went into effect for chemical manufacturers. At that time, they were required to develop material safety data sheets such as this and include them in the next shipment of that substance that went out into the manufacturing sector. In 10 days, every manufacturing employer in this country will have to have a material safety data sheet covering every hazardous substance in use in that workplace; and every employee of those manufacturers will have to have access to that information, ready access to that information. Also, every container of the substance which has been identified as being hazardous under this standard will have to be labeled with specific information as to what the hazard is, what the employees need to do to protect themselves from the hazard, and where they can go to get additional information, where the material safety data sheets is.

Further, there has to be a training program in place, already accomplished, in 2 weeks, for every employer in the manufacturing sector, that tells employees how to read material safety data sheets, how the system works, what the label means, and what they need to do to protect themselves.

It is a very, very comprehensive standard.

Senator NICKLES. Now, Mr. Tyson, to bring this more into the everyday standards, I doubt that employers or employees are going to be handing out six or eight pages, whatever you have there. Are you talking about having cases where a firm uses chemical solvents for cleaning that are hazardous and if they are in eye contact or if they are inhaled, that upon that type of contact, eyewash is recommended. You are not going to be able to give a six-page standard.

Mr. TYSON. It will be on the label if there is a container. If it is not practical to have a label on a container because of the type of hazard that may be presented, then the area will have to be placarded to give that information to employees.

But the key is, the label tells you of the hazard. The label tells you what the substance is, or some identifier for the substance; it tells you of the hazard; it tells you very specifically what the hazard is, and it tells you how to protect yourself.

Then it keys to the material safety data sheet which you as an employee have to be able to have access to during your working day, ready access, so that you can go and get much more data if you desire it.

In addition, that right is available to health professionals, to collective bargaining representatives for these employees, and other individuals who may need to see that information.

Senator NICKLES. Mr. Tyson, thank you very much.

Senator Metzenbaum, do you have a followup?

Senator METZENBAUM. Yes, a couple of questions.

Mr. Tyson, as I understand it, the Hazard Communication Standard does not cover former workers; it does not cover exposures to hazardous substances in the past, and it does not apply to public service employees such as firefighters, hospital workers, or sewage workers in the 25 States that do not have State OSHA plans, including my own and the chairman's.

Given the long latency period for many occupational diseases, shouldn't we be concerned that these millions of workers are not being notified of their risks or advised about appropriate medical monitoring?

Mr. TYSON. Senator, you raise a good point, and there are two answers to it. First, although the standard does not directly apply to the groups that you mentioned, there is another standard which we mentioned earlier, the Access to Medical Records and Exposure Monitoring Records, which does. That standard applies to every place that OSHA applies to. You mentioned firefighters. OSHA does not directly apply to firefighters unless they are under a covered State plan. So there are firefighters in some States—your State, for example—who are public employees that the OSHA Act does not get to. It is a relatively small group, but we can address that separately, if you wish.

But under the Medical Access Standard, an exposure record is defined as any information which identifies the substance; and a material safety data sheet, which is this great wealth of information which is going to be generated as a result of the Hazard Communication Standard, is considered an exposure record under the Access Standard. Therefore, even though there is not direct application of the Hazard Communication Standard, employees, through the vehicle of the Access Standard, will have the ability to get that information. We have been all the way around the barn.

Senator METZENBAUM. I wish it would be as easy as you make it sound. I am afraid that the road will be a rocky one ahead of us.

Mr. TYSON. I will not disagree that it is a rocky road to try to implement a far-reaching standard like this. It is a challenge that OSHA recognizes and is prepared to meet. But we recognize going in that it is going to be a tough burden.

Senator METZENBAUM. In connection with that same question, it is my understanding that even for current workers, the training, labeling, and data sheet provisions of the Hazard Communication Standard do not require that employees be given any information regarding what type of medical surveillance is appropriate for their exposure and do not require that employers provide medical exams for workers exposed to hazardous substances.

While educating workers to recognize and understand workplace hazards is clearly important, can it really take the place of a notification program aimed at workers for whom medical surveillance might save lives?

Mr. TYSON. I hate to have to criticize your bill, Senator, and I apologize.

Senator METZENBAUM. I do not mind, I do not mind you criticizing my bill. Just tell us how to make it better, and we will do it.

Mr. TYSON. All right, sir. First, let me note that in your bill, you propose to begin the notification process with the 20 or 24 specific health standards which OSHA has already promulgated. Your bill contemplates five a year; NIOSH estimates that it may take 3 years to do the first one; you can take either end of that estimate.

As a practical matter, those standards that your bill would initially begin with, those substances, do contain requirements for medical surveillance, do have requirements for medical testing, and that information has to be made available to employees.

Senator METZENBAUM. I do not mean to criticize the program that you are so enthused about, but let me ask, how do you expect to enforce the standard if 1 or 10 or 100 or 10,000 of the 600,000 employers covered do not provide the required notice or training to employees?

Mr. TYSON. OSHA will begin in 10 days a very intensive inspection effort. In every inspection conducted in the manufacturing sector, OSHA will evaluate the compliance with the Hazard Communication Standard. And, as I think we have demonstrated fairly recently, OSHA does have the ability on occasion to take someone out and give them a good woodshed treatment. And I think Secretary Brock has made it clear that he will be willing to do that again where it is warranted.

The enforcement provisions of the act will be applied. This body developed the act, and I think we value your wisdom.

Senator METZENBAUM. Mr. Tyson, I will not hold you longer. I think you have acquitted yourself well in your appearance today, even though some of your positions I disagree with. We are sorry that you are going to leave the Government. Most of us, I think, agree that you have done a good job. But we wish you well in your new endeavors.

Mr. TYSON. Thank you very much, Senator.

Senator METZENBAUM. Mr. Chairman, I have some additional questions for Mr. Willmore of Justice, which I will submit for the record. But I do want to make one comment. That is, when Mr. Willmore was talking about all the different kinds of lawsuits and things that could occur, I think it is true, you might have those kinds of lawsuits, but as I heard you recite them and having practiced law before I came to the Senate, it is my view that you might have been able to file the lawsuit, but I doubt if you would be able to win many of them as you spelled them out. I just do not think that the legal theories would hold up as you spelled them out, and I am not willing to have this great excitement or concern about lots of new litigation. We are all very litigation-concerned at the moment, but I do not think that that would occur. I do not want to argue the point with you, but I just do not want the record to be silent on my own view of your legal observations.

Thank you, Mr. Chairman.

Senator NICKLES. Senator Metzenbaum, thank you.

To all of our panelists, we thank you very much. And again, time is limited, as I am sure there are additional areas which all of us would like to explore with you.

Thank you very much.

Mr. TYSON. Thank you, Senator.

Senator NICKLES. If our next panel would come up, we would appreciate it. I apologize. I will step out and testify over in the House and will return.

Senator METZENBAUM [presiding]. Our next panel consists of Willie Hall, of Augusta, GA; Patricia Ware, of Villa Hills, KY; George Hight, Bluffton, OH; and William Ailiff, of Garrettsville, OH.

We will ask each of the witnesses to limit their testimony to 5 minutes, and then we will have questions which you may be able to elaborate on.

Patricia Ware, of Villa Hills, KY, worked at the Miller Shoe Co., in Cincinnati, from 1971 to 1984. Would you tell us your own situation, Ms. Ware?

STATEMENT OF PATRICIA WARE, VILLA HILLS, KY; GEORGE HIGHT, BLUFFTON, OH; WILLIAM AILIFF, GARRETTSVILLE, OH; AND WILLIE HALL, AUGUSTA, GA, ACCOMPANIED BY DR. WILLIAM JOHNSON

Ms. WARE. In August 1984, I came down with pneumonia. Through the whole month of August, my family physician was treating me for the pneumonia, and I was not getting any better. So he sent me to see a lung specialist. This lung specialist admitted me to a hospital and did lung biopsies, and the diagnosis of those biopsies was that I had interstitial pneumonia caused by the inhalation of oils and chemicals.

That later developed into what they call interstitial fibrosis. Through the infections, it has turned over 50 percent of my lung tissue into fiber. I have one infection after the other. In the last year I have been in the hospital about six or seven times.

When I was first diagnosed, I had lung loss of about 40 percent. Since I have had more infections, they say each time I have infection I have more lung damage, and they have not been able to bring this under control. So due to that fact, I have lost over another 10 percent of my lungs.

I feel that if I keep going at this rate without some kind of a miracle, at 10 percent a year, within the next 5 years, I am going to be dead.

There are an awful lot of emotional problems with something like this. You go from being a very active person and having a very busy life to what I consider not a life anymore but an existence. It is very hard on your family. And it is so frustrating, because I feel it should have never happened; it did not have to happen, if we had known. We did not have any idea what the things we were working with could do to us. And I am not the only one that has been affected by the chemicals that I work with.

I feel like if we had known, some way we could have gotten some help—through the Government, fighting with management over it, seeing our physicians to make sure whoever was affected, if we

were OK. But it seems to me somebody had to know that there is something in those chemicals that could hurt us like that, and that there should have been someway to do something to prevent what happened to us.

Senator METZENBAUM. You are not able to work anymore at all?

Ms. WARE. No, sir.

Senator METZENBAUM. And do I understand that you are on oxygen a considerable portion of the day?

Ms. WARE. At least 10 hours a day; longer, if I am having problems. When I am having infections, I am on oxygen 24 hours a day.

Senator METZENBAUM. And have you been able to move around your house, or have you been limited in that respect?

Ms. WARE. Very limited. I have not seen the upstairs of my house since shortly after I got sick. I cannot climb stairs; I cannot breathe when I climb stairs. I can walk from my kitchen to my bedroom, and I am huffing and puffing.

Getting dressed is an effort.

Senator METZENBAUM. You first learned that you were having this problem when you went to your own doctor. There was no advice of any kind from the company?

Ms. WARE. No, sir.

Senator METZENBAUM. And if you had known earlier, what would you have done?

Ms. WARE. What do you mean, if I had known?

Senator METZENBAUM. Well, if you had known that you had this exposure to these chemicals. Do you know what kind of chemicals they were?

Ms. WARE. It was neoprene cements and cleaners, solvents.

Senator METZENBAUM. What did the employer say when you told them what had occurred to you?

Ms. WARE. The first thing they told me was, well, I could go ahead and file a workers compensation case if I wanted to, but they would fight it. They did not believe what I was telling them that the doctors had found in my lungs.

Senator METZENBAUM. If you had learned earlier that you were at risk of getting this disease and the illness that you now have, would you have acted differently?

Ms. WARE. Yes, sir.

Senator METZENBAUM. Would you have quit your job?

Ms. WARE. First of all, I was president of the union in that factory and being president of the union it would have been what I would consider part of my job to find out how many people had been affected, what could be done to put a stop to it, was there anyway that we could work with this kind of material without being hurt.

I would have, as I have done since I found out what happened to me, informed people in my factory what has happened to me and asked them to see their doctors to be checked, to find out if they are OK or not.

Senator METZENBAUM. Do you know whether your exposures were to chemicals that have been studied by the Federal Government?

Ms. WARE. Yes, I do.

Senator METZENBAUM. And have they been studied by the Federal Government?

Ms. WARE. Yes, they were.

Senator METZENBAUM. And did you have any notification from the Federal Government, or did they give you any advice at all until after you were ill?

Ms. WARE. No, sir.

Senator METZENBAUM. Have they been at all helpful since you have become ill?

Ms. WARE. No, sir.

Senator METZENBAUM. Have you gone to the Government to ask for some assistance?

Ms. WARE. What I did, in the early part of 1985 after I became sick, I read an article in the Cincinnati Business Courier, and this article was talking about NIOSH making studies in a lot of different industries, and that at the end of these studies, they had requested that the Department of Health and Human Resources notify people who were involved in these studies of the harmful substances that they were working with.

According to the newspaper article, the Department of Health and Human Resources answers were they did not want to notify people about this because, as you heard here this morning, it cost too much money. Their second reason was if they did notify people in turn, employees were suing employers—which I feel is none of their business; I feel that as employees, we have a right to know. All right. So when I read that newspaper article, I called NIOSH, and I asked them had they ever done a study in the shoe industry. They told me yes, that they had done a study in Red Wing, MN, in 1982, and they sent me a copy. I asked them could I have a copy of their findings, so they mailed it to me. And they studied people who were working with the rubber cement, the cleaners, the solvents, and all that, and their findings were that these chemicals cause skin diseases, they cause miscarriages, and they cause a lot of different types of respiratory diseases.

Now, this information was found out in 1982. I sit here this morning, and I have listened to these people complain about the costs. And it made me very angry, because there is a cost to making these studies, too; but if these studies are made, and they sit in someone's file, and no one is told the findings of these studies, that is an awful lot of waste of money, too. Besides that, the people that are involved do not know what is going on, and we are the ones that end up paying for it in the long run.

Senator METZENBAUM. I appreciate your testimony very much. I think you have summed it up, the very conclusion there as to the real problem that exists at the moment and why I believe we need this legislation.

Mr. Hight, we would be happy to hear from you, sir.

Mr. HIGHT. I started in the rubber industry in 1957 with Cooper Tire in Findlay, OH, and worked with the compound and mixing department until 1976.

In 1979, I started having kidney infections and bladder infections and was treated that way. In 1980, I was diagnosed as having bladder cancer, and in 1981, they removed my bladder and a few glands

and part of my lower intestine, due to the fact it was cancer, caused by the chemicals that I had worked with all those years.

I was never told that any of the chemicals were harmful to me; nobody in the plant even knew what we were working with. And it has caused me a lot of hardship since then, due to the fact that I cannot travel too far anymore unless I take a lot of equipment with me, and I am always afraid of having problems with the equipment that I wear.

And this right-to-know law, we were just notified of that 2 weeks ago. The company had a meeting with the employees and told us about the chemicals that we handled, that they had to be labeled and what we could do to look up the information on them. And I looked up a few, and all of them that I had worked with before were labeled with cancer-causing materials. That is part of my problem right there.

Senator METZENBAUM. Your surgery removed your bladder, your prostate, part of the lower intestine?

Mr. HIGHT. Right.

Senator METZENBAUM. And in order to get around now, you have to wear a sack?

Mr. HIGHT. Right.

Senator METZENBAUM. And you were off work, convalescing, for about a year, and now you are back, working for the same company on a different assignment; is that it?

Mr. HIGHT. A different assignment, right.

Senator METZENBAUM. How has all of this affected your family relationships?

Mr. HIGHT. Quite a bit. It caused a lot of hardships on my wife. It caused a lot of hardships on me, actually, moneywise, being off work for a year. And we do not travel like we use to. We do not do hardly anything like that anymore on account of the problems with the bag that I have to wear.

Senator METZENBAUM. If you had learned about this earlier, if they had given you the same notice they did a couple of weeks ago, what would you have done?

Mr. HIGHT. I would have, I believe, looked for another job. I would not have stayed there.

Senator METZENBAUM. You would not have stayed there?

Mr. HIGHT. No, no.

Senator METZENBAUM. You first learned about the problem of cancer and the causative factor from your doctor, not from the company?

Mr. HIGHT. From my doctor, right. The company never told us anything about it or gave us any kind of examination or anything to show that the chemicals we worked with were hazardous.

Senator METZENBAUM. Do you know whether there have been any studies linking bladder cancer to some of the chemicals used heavily in the rubber industry?

Mr. HIGHT. Just according to what my doctor told me when he operated on me. He said the chemicals that I worked with are what had caused my bladder cancer. And he said that they had run studies at the Medical College in Toledo and at the Cleveland Clinic, that the two of them had worked together on this, and he said they

know for a fact that some of the chemicals that I had worked with and the dyes had caused the cancer.

Senator METZENBAUM. Thank you very much, Mr. Hight. Your testimony and Ms. Ware's testimony are extremely helpful to this committee and its deliberations.

Mr. Ailiff, we are very happy to welcome you to the committee. I understand you also come from Ohio, from Garrettsville, OH?

Mr. AILIFF. Yes, sir.

Senator METZENBAUM. Do you want to tell us your story, if you will, Mr. Ailiff?

Mr. AILIFF. Well, my trouble all started in 1984, when I started getting dizzy just like I had the flu. So I thought it was the flu. I would go outside, you know, and stand there, and I would get really deathly sick. And I thought, well, I would get over it. Then I would feel a little bit better, and then it would get so I could not breathe. I just could not get my breath. I would walk a little ways, and I would have to sit down. I did not have any strength in my arms or anything.

And the place was so dusty that I thought the dust was what was doing it. And it kept on, and finally one day, I would blow up, get mad over nothing. Everybody that works in my place does that.

Senator METZENBAUM. I missed that last sentence

Mr. AILIFF. I get mad over nothing, and everybody that works at the shop, I do the same way. And finally, one night, I just got so sick, I said to my wife, "There is something wrong here." My boy and wife work there, too. And I said, "We are all quitting. There is something wrong here. I do not know what it is."

So I quit, and I stayed home about 2 months. I could not work. There were a couple of different places I put in that guys had called me to go to work, and I would say, well, I will take the job, but by the time I would get to the job, I would be just too weak, too sick to go, and I could not breathe.

So I was reading an article in the paper about methylene chloride. So I called about it, and the guy said, "Well, go down to the clinic in Cincinnati, and they can tell you." So I went to Cincinnati, which is 175 miles from where I live. I went down there, and they ran all these different tests, different doctors—it must have been 10 doctors, the different things they run on me—and they told me I had organic brain damage; I had a double heart tumor; I have nerve symptoms that are bad, and my memory and everything. And I cannot breathe, and it is just a mess. My family life, I knew it was falling apart. Just different things were happening to me, nerves and everything.

And what gets me is the company hauls this stuff out—my boy and everybody—they haul it out back. They talk about OSHA, they give them a 3-day notice, and that place is a mess. They clean everything up and haul it out in the back, in the parking lot. They have 10 acres. They haul this stuff out back and hide it. As soon as OSHA leaves—the air in there is clean; as soon as they leave, it is back to normal. They haul everything back in and start dumping these chemicals, methylene chloride, isocyanates. And the kids told me later—nobody knows this—they have lead chromate they use for a dye. They have all this stuff in there, no labels, nothing. They put on a barrel that has a number, like "Union Carbide 936". And

they have 50, 60 barrels sitting around with numbers, and nobody knows what is in them. And they will not tell you anything. You ask them, and they say, "None of your business," in a roundabout way, and if you ask too much, they get rid of you. It is a nonunion job.

Senator METZENBAUM. Have you worked all your life?

Mr. AILIFF. Yes, sir. I never got a penny of welfare, nothing, in my life.

Senator METZENBAUM. You have never been unemployed?

Mr. AILIFF. No, sir.

Senator METZENBAUM. And now you have been out of work how long?

Mr. AILIFF. A year and a half. And I have not received a cent. I have not worked in a year and a half.

Senator METZENBAUM. And how have you been able to——

Mr. AILIFF. My wife works, sir, and keeps me. And I live with my daughter. I sold my home. I had a home worth about $80,000, and I had a place at the lake. I got rid of everything. And I had to sell it for almost nothing, because I needed the money.

Senator METZENBAUM. Let me read you a report from your doctor, which is the Greater Cincinnati Occupational Health Center at Providence Hospital in Cincinnati. I think it speaks for itself.

DISCUSSION

I am quite concerned by the EEG abnormalities which, when coupled with the neuropsychological evaluation, pose for significant organic brain disease. The cause for this loss of function is solvent-related. Most notable would be methylene chloride, but also other degreasers that Mr. Ailiff has used. They have an ability to cross the blood-brain barrier causing dysfunction of normal neurologic functioning and actually destroying central nervous system tissue. Methylene chloride also has a metabolic product, carbon monoxide, which has a similar capacity to enter the brain, disrupting oxidative phosphorylation and causing destruction of nervous system tissue as well.

He goes on to say:

I am quite concerned by Mr. Ailiff's respiratory problems, specifically, his chest x ray and pulmonary functions, which show pathologic alterations. Coupled with the symptoms and physical findings, the most likely cause for this problem is isocyanate exposure.

Mr. Ailiff, how did you first learn that your health was at risk due to your exposure to chemicals on the job?

Mr. AILIFF. Well, it was about 2 months after I quit. I found out when I went down to Cincinnati, and he told me that that caused it, because I used that stuff every day. I washed my hands in it, and we washed the machines down. I am a maintenance man, electrician, maintenance. And we used it all the time. We would wash our hands in it, and nobody ever said it was dangerous. They would give you a 5-gallon can, and you would wash the machines with the stuff. It would go all over your clothes.

And I would be walking along, and I would put my hand up, and I would think my nose was bleeding, and it would be full of blood. So I went into the bathroom at different times. The owner's nephew came in one time, and I said, "I have got this awful nosebleed." And he said, "Don't worry, all of us have that who work here. You are not the only one."

And I said, "I have got splitting headaches. Every day I have a headache." I would take aspirin like mad. Before, I was never to a doctor. In about 30-some years, I had never seen a doctor. I was always healthy. You can check on that. I never was sick.

And I said, "I am awful weak, and nosebleeds."

And he said, "Well, that happens to everybody that works here. We all get nosebleeds. It is just normal."

Senator METZENBAUM. Who said that?

Mr. AILIFF. This is the owner's nephew.

And I said, "Well, there is something wrong with people getting nosebleeds like that. I have never had a nosebleed. And every time I am walking now, I feel like there is just water running down my nose, and my whole hand will be full of blood." And I would have to go in there and run cold water on my face to get it to stop.

And the last time, I said to my wife, "That is it. We have to get out of here. There is something wrong." So I made her quit.

Senator METZENBAUM. If the Government had notified you earlier, would you have quit your job?

Mr. AILIFF. Yes, sir, because I could get a job anywhere. I am a maintenance man, and I could have gone—I would not have stayed there 5 minutes if I would have known, because like I say, as an electrician and maintenance man, I could get a job tomorrow morning if I was able to work.

Senator METZENBAUM. But you could not get a job now.

Mr. AILIFF. Well, I could not; I work about 10 minutes, and I am worn out. How could I—he would probably fire me right off, because I could not do my job.

Senator METZENBAUM. Do you know if anyone else who worked with you was affected by exposure to these chemicals?

Mr. AILIFF. Well, sir, there have been four guys taken out of there to the hospital, and two of them quit as soon as they were taken out. There is one kid who is still working there with them. He was taken to the hospital, and he stayed in there.

Senator METZENBAUM. What is the name of the company?

Mr. AILIFF. Marbal. It was Auburn—out of Chagrin Falls—they are out of Chagrin Falls.

Senator METZENBAUM. What has been the attitude of the company with respect to their failure to notify you of the problems?

Mr. AILIFF. They just do not talk. They just do not say anything to me about it. They are still using it.

The kids were over at my house last Friday. They came over. They found out—I do not know how—I had never seen the kids and did not know them until then. One is the nephew, but the other two kids, I did not know.

And they came over and said, "Are you sick?" And they were asking me, "What are the symptoms? We are all sick, and we want to know." They said they have 12 buckets sitting there, open, and a 30-gallon drum of methylene chloride. And they have a fan blowing on it. And what they do now, instead of dumping it in the trash and down the sewers like they used to do, they let the air evaporate this. And they told them that is what they are doing.

And the kids signed this statement—I took them Saturday to a lawyer and signed a statement on it, because I did not know what

to tell them, and I said, "He can tell you. He knows more about this disease than I do. I do not know that much about it."

So they said they are letting the buckets just set there through the shop. There are no windows in the building, and that stuff is blowing through the shop and everybody is getting it, and they do not care.

Senator METZENBAUM. You had a workmen's compensation case, and you won the case. What has the company done?

Mr. AILIFF. Well, they appealed it. They will not——

Senator METZENBAUM. The company is appealing it?

Mr. AILIFF. Yes. I do not get a penny yet. I have not received any money.

Senator METZENBAUM. You have not received a penny at this moment?

Mr. AILIFF. No, sir.

Senator METZENBAUM. And you have had to sell one house or two homes?

Mr. AILIFF. Well, the one at the lake is up for sale, and the other one I had to sell, because like I say, I was going to lose it anyway; I could not make my payments. And I had to sell it for whatever I could get, which was a lot less than that. I ended up getting $55,000 out of it.

Senator METZENBAUM. I thank you very much for your testimony.

Mr. Hall, we are happy to hear from you, sir.

Mr. HALL. I am glad to be here.

I worked for Augusta Chemical from 1963 to 1968, making BNA and SSW. I was the distiller, and I was the grinder, and I was the mixer, me and a fellow named Flatten. And after Flatten died, they made me head manager of it. He died of cancer. And they had another gentleman, Roger Huff. He had the same thing that I have.

So I became ill in 1976 of that, from BNA and SSW. And when I was working, nobody told me that stuff was bad for your health.

So they removed my kidney, my bladder, and also I have had two strokes since then. And since then, instead of getting better, I am getting worse. It has gotten so I just cannot cope anymore.

Senator METZENBAUM. Is that your doctor who is with you?

Mr. JOHNSON. I am Dr. William Johnson. I am a former official of the National Institute for Occupational Safety and Health. I was in NIOSH from 1971 to 1973, when NIOSH first looked at the Augusta Chemical Co. problem. We had an exposure there to a chemical called beta-naphthylamine, which was known to cause bladder cancer and had been recognized as causing bladder cancer in the United States since the mid-1930's, when several cases were documented in the Du Pont Co.

Yet, beta-naphthylamine continued to be handled in Augusta, GA.

I think the U.S. Government in Mr. Hall's situation owes him an apology. In 1972, at the time when Mr. Hall had left the employment of the company, the Federal Government had in their files in Cincinnati, OH, the names of workers on microfilm that had worked at the Augusta Chemical facility. Mr. Hall finally showed up with bladder cancer that required major surgery in 1976. While

he was developing his bladder cancer, NIOSH failed to notify him as a former employee of his significant risk. And indeed, this is a significant risk. It is not just a statistical risk. Two out of three individuals that worked at Mr. Hall's operation developed bladder cancer.

There are other situations like Mr. Hall's where NIOSH has records on suspected trouble with the same chemical and similar chemicals where notification has not been initiated. It was only, I think, through adverse media publicity, pressure on NIOSH by organized labor, and pressure on NIOSH by a number of other concerned professicnals, that the Augusta Chemical notification in fact ever did take place.

The number of cases of bladder cancer have been documented through those studies, and unfortunately, we have just a skeleton of a continuing program of medical surveillance going on in Augusta, GA, to try to head off at an early stage the diagnosis of bladder cancer so that it can be effectively treated.

I think it should be pointed out that Mr. Hall, at the time of his diagnosis by a cancer specialist in Augusta, had far-advanced cancer. He had symptoms of blood in his urine while he was actually under the employment of the company. He left the company with a minimization of those symptoms by the company physician, who attributed them to strain. He continued to have problems with his bladder. He was unable to seek good continuing medical care for financial reasons, and it was only a medical crisis that resulted in his quite extreme surgery in 1976, again, at a time when NIOSH had his name on Government records.

Senator METZENBAUM. Doctor, is there any question in your mind that if Mr. Hall had been notified sufficient time in advance of the dangers of being exposed to BNA, that he would not be sitting here today, having had an operation for cancer?

Dr. JOHNSON. Senator, if he had been notified as to the hazards of beta-napthylamine and the extreme risk of bladder cancer associated with that substance, I do not believe he ever would have worked with that material.

Senator METZENBAUM. Is that right, Mr. Hall? If you had known what the problems were in continuing to work with the BNA, would you have quit your job?

Mr. HALL. Yes, I would have. I know I would have been in better health. And I could have made up the time on another job, rather than staying there. I sure would have; I sure would have quit.

Senator METZENBAUM. You are 57 years old?

Mr. HALL. Yes, sir.

Senator METZENBAUM. And you have had your bladder removed, one kidney removed; you have not been able to work since the problem developed, and I understand you have also suffered two strokes since 1976; is that correct?

Mr. HALL. Yes, sir.

Senator METZENBAUM. And all this could have been avoided if you had been notified and had been able to change your job?

Mr. HALL. Yes, sir.

Senator METZENBAUM. Do you feel the Government let you down in this instance?

Mr. HALL. Yes, sir. I feel like they did do that.

Senator METZENBAUM. Let me ask you, Ms. Ware. Do you think the Government let you down in failing to see to it that you were notified of the risks that you were being exposed to?

Ms. WARE. Yes, I certainly do.

Senator METZENBAUM. How would you answer that question, Mr. Hight?

Mr. HIGHT. I feel it was the factory I worked for, for not notifying us that the stuff we worked with was dangerous.

Senator METZENBAUM. And Mr. Ailiff?

Mr. AILIFF. Well, I figure the Government did, because I do not think the factory would have notified me. Somebody has got to force them to take action. And I think if the Government does not do it, it is not ever going to be done.

Senator METZENBAUM. Mr. Hall, what has your employer done for you since this has occurred? Are you on some compensation, or what is the situation?

Mr. HALL. No, sir.

Senator METZENBAUM. Have they done anything for you?

Mr. HALL. No, sir.

Senator METZENBAUM. Nothing at all?

Mr. HALL. I sued them.

Senator METZENBAUM. Pardon?

Mr. HALL. I sued Augusta Chemical.

Senator METZENBAUM. Do you have a lawsuit pending now, or has it been disposed of?

Mr. HALL. It has been disposed of.

Dr. JOHNSON. He had a lawsuit against Augusta Chemical with a number of other workers. Fortunately, he was able to settle his lawsuit before the case was thrown out by the Georgia Supreme Court, which said that the workmen's compensation statutes superseded any right to proceed with further litigation.

Senator METZENBAUM. I want to thank each of the panel members and to you, Doctor, for being with us today. I think your testimony has been extremely helpful. And on behalf of all the members of this committee, many of whom I am certain will read yor testimony, thank you very much. It means a lot to us.

Ms. Ware, did you want to say something?

Ms. WARE. Yes. I agree with this gentleman down here. I feel that it is going to take people like you, people in Government, to get on the chemical companies, because chemical companies will send materials into a factory like they did mine, with absolutely nothing on them except "highly flammable," and then their name, where it came from. And until someone forces them—and I honestly believe they know what is in there, and I believe they know what it is going to do to people. And I feel that someone has to force them to tell us, because we have a right to know.

Senator METZENBAUM. Thank you very much. Thanks to each of the members of the panel. We are very grateful to you.

Mr. AILIFF. Thank you.

Senator METZENBAUM. According to our schedule, the next two witnesses on panel 3 were to be from the National Association of Manufacturers and the American Mining Congress. The chairman has asked me not to hear them at this moment; he wants to be present at the time that they are heard. So for that reason, we will

not hear them at this moment, but will go on to panel 4, the American Cancer Society, Dr. Irving Selikoff, director emeritus of the Environmental Cancer Center, Mount Sinai Medical Center, NY; John F. Finklea, the University of Alabama, Division of General and Preventive Medicine, Birmingham, AL; and Dr. Nicholas A. Ashford of the American Public Health Association, professor of technology and policy, Massachusetts Institute of Technology at Cambridge, MA.

Dr. Selikoff, we would be glad to hear from you. We try very hard to get the best witnesses in the country, and then when they get here we tell them, "Please hold your remarks to 5 minutes." I hope you will understand, but that is the situation we are in.

We are happy to have each of you with us this morning.

STATEMENT OF DR. IRVING J. SELIKOFF, DIRECTOR EMERITUS, ENVIRONMENTAL CANCER CENTER, MOUNT SINAI MEDICAL CENTER, NEW YORK, NY, ON BEHALF OF THE AMERICAN CANCER SOCIETY; DR. JOHN F. FINKLEA, DIVISION OF GENERAL AND PREVENTIVE MEDICINE, UNIVERSITY OF ALABAMA, BIRMINGHAM, AL, AND DR. NICHOLAS A. ASHFORD, PROFESSOR OF TECHNOLOGY AND POLICY, MASSACHUSETTS INSTITUTE OF TECHNOLOGY, CAMBRIDGE, MA, ON BEHALF OF AMERICAN PUBLIC HEALTH ASSOCIATION

Dr. SELIKOFF. Well, thanks very much, Senator.

I think I need not say anything with regard to my statement; that can go into the record, and we will make additional comments.

The Cancer Society, incidentally, is no newcomer to this problem. Back in 1980, the society board of directors approved a resolution supporting right-to-know in the workplace with regard to exposures to various industrial agents including carcinogens, and just 2 months ago, the society issued an official statement supporting your bill, S. 2050, and stated that it would work with Members of Congress to secure such legislation to prevent and modify the risks of occupationally induced cancer. The Society has long supported both the direction and thrust of what you are doing, and in this case, your specific work that is now going on.

I would like to touch on some of the highlights of the problems, because there are real problems here, as you have suggested, and as some of the previous witnesses have stated.

First of all, we heard this morning—and I think very well—the question being raised that if OSHA is now going to put in a notification program, why do we need Senator Metzenbaum to come along and do something more.

I think OSHA should be encouraged in this. It is a long time overdue, but I think anything they do is all to the good to notify. Now, there are problems with what they are going to do, but to the extent that they are going to be helpful, OSHA should be supported.

However, they do not really address what you are addressing. They are addressing things like safety data sheets, while you are addressing people. There is a big difference. I heard some of these statements here now, that if some of these people had been notified about isocyanates and beta-naphthylamine and oxidizing agents in

tire works and so forth, they may not have been here, suffering from cancer.

So that what you are doing is, in our opinion, terribly important, concentrating on people—also, concentrating on people who suffered from our mistakes in the last 30 or 40 years, studies that were not done, research that was never held, regulations that were never formed, and these people went to work thinking that, in our great country, they were being protected, and they were not. And here they are now, 30 or 40 years later, and they are now at serious risk of dying of cancer.

Second, it is important to have access. But access is not information; it is access to information. I am in favor of what OSHA is doing to provide access, but God knows, that has not worked in the past. First of all, access to 575,000 pieces of information about chemicals, even the most wise workers are not going to be able to digest that very rapidly.

Moreoever, that is a very, very general program. Let us say, in a factory—by the way, it does not necessarily go to the users of the product. You can have 100 people working in a factory, and they are going to have access to what that manufacturer knows, but it might be sold to a user that may employ several million people who are not going to have the same access as well.

But in any case, this is a very dilute approach, and what you are doing is to focus on very specific problems. And that is why I think your bill is called the high-risk bill. You are going to get information to the people who are at greatest risk. Well, that is a very useful approach, because we cannot do everything. We have limited resources. There are many people, there are many agents, and what you are doing is to focus on those at the highest risk, and basically, that is on the people who are going to die.

With regard to access and knowledge, they are really two different things. Last month, we examined 290 sheet metal workers in Miami and in Houston. When we asked them about the information that they had concerning their asbestos exposure in the construction industry, not one had been given any information about their employers; they did get information from television, but not from their employers. Moreover, the question of testing people at risk—and they are at very serious risk—not one had been given any medical examinations.

Moreover, there is quite a difference between what should be done and what is often done. When the asbestos standard was put in place, it included the obligation on every employer using asbestos in the country to do at least one dust count in the next 6 months to see whether the standards would apply. The bill went into effect on June 7, and on December 6, we wrote to some 10,000 workers about the dust counts that they had seen in those 6 months; 6,500 replied, and only 3 percent had seen at least one dust count in that time, and they generally worked in Navy shipyards.

So that this obligation just has not been accomplished.

So that from the point of view of notification, I think OSHA is right to notify as much as possible, but S. 2050 goes far beyond this and focuses on people at the highest risk.

Now, the question I have heard this morning is, can it be effective? Not completely. We do not know enough. There is a great deal that has to be done to apply it. But by the same token, it is the best we can do at this time. The question that you have posed for physicians and for scientists and for Government is what is the best we can do with the knowledge that we have today—not with what we will know 10 years from now or 20 years from now; that research can go on at the same time. But let us at least apply what we now know.

Moreover, I heard Dr. Melius say that ERC's would have a lot of trouble, and we do not have enough doctors who know enough about occupational disease, that is true. But by the same token, the facilities will come into being if the requirement and demand for them is seen.

If we use that kind of approach, we would never have had any heart surgery in this country, because we had no trained heart surgeons 15 to 20 years ago. But as the requirement for heart surgery, for coronary bypass surgery and so forth became apparent, all of a sudden, we have had thousands of excellent cardiac surgeons going to work on this.

The same thing with Hodgkin's disease. We had no way of treating Hodgkin's disease 15 to 20 years ago. It had a 100 percent mortality. But in the interim, as Dr. Kaplan's work came to be known, we have a whole cadre of physicians now able to utilize radiotherapy and chemotherapy and so forth, and we are now able to save 50 percent of people with Hodgkin's disease, and so forth.

So that as medical requirements become known, the medical profession will, in my opinion, respond, and 15 years from now, we may have a lot of good physicians in this country, many hospitals in this country, knowledgeable, and capable of treating occupational disease.

Finally, we live in a very real world with very limited resources, and the best use of such limited resource is the way you are going about it. Moreover, the possibility of primary prevention is long past. The exposures have taken place. Shall we throw up our hands now and say these two to three generations of workers are wasted, and there is nothing we can do?

On the contrary, there are in many circumstances—and I thought of this as these unfortunate people with bladder cancer were discussing this with you—much that can be done through secondary prevention of cancer by maintaining surveillance on people with the greatest risk.

I strongly support, and the American Cancer Society strongly supports the purposes of S. 2050 and will do everything possible to work with Members of Congress to strengthen it as you see fit.

[The prepared statement of Dr. Selikoff and responses to questions submitted by Senator Metzenbaum follow:]

TESTIMONY OF

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NEW YORK, NEW YORK

AND

MEMBER, PUBLIC ISSUES COMMITTEE
NATIONAL BOARD OF DIRECTORS
AMERICAN CANCER SOCIETY

ON BEHALF OF THE

AMERICAN CANCER SOCIETY

REGARDING S. 2050
"HIGH RISK OCCUPATIONAL DISEASE
NOTIFICATION AND PREVENTION ACT OF 1986"

BEFORE THE

SUBCOMMITTEE ON LABOR
COMMITTEE ON LABOR AND HUMAN RESOURCES

UNITED STATES SENATE

MAY 15, 1986

I am Dr. Irving J. Selikoff. I am Director Emeritus of the Environmental Cancer Center at Mt. Sinai Medical Center in New York City. I am here today representing the American Cancer Society as a long time volunteer, and member of the Public Issues Committee of the Society's National Board of Directors. I would like to comment on S. 2050, "The High Risk Occupational Disease Notification and Prevention Act of 1986."

First, let me tell you that at its March 8, 1986 meeting, the American Cancer Society (ACS) Board of Directors approved the following resolution:

> RESOLVED: The American Cancer Society supports the intent of S. 2050 and H.R. 1309 and will work with Members of Congress to secure legislation to prevent and modify risks of occupationally induced cancer.

This recent action is consistent with a policy statement adopted by the Society's Board of Directors in 1980, which reads:

> RESOLVED: The American Cancer Society believes that where there is information that chemicals or other industrial agents used in the workplace are known to cause cancer, or are scientifically suspect of causing cancer in humans, the employee has a right to such information.

We believe that Senator Metzenbaum and Senator Stafford have presented a realistic, practical bill, which, if enacted, would accomplish a very important objective: establishment of a non-threatening system for monitoring workers in business and industrial situations who are, by the very nature of their work, exposed to substances known, or suspected of being toxic. By

being monitored in an organized, standardized way, those who may be receiving unacceptably high exposure to these toxic substances can be identified, hopefully before it is too late to reverse the situation, and measures can be taken by the worker and management to reduce the exposure.

Mr. Chairman, primary prevention of cancer, of course, is the most desirable means of reducing cancer incidence. A prevented cancer does not have to be treated.

The American Cancer Society's purpose is to do everything possible to eliminate cancer as a serious human health threat. Our principal efforts are through education, research and service to the cancer patient. We support the proposed legislation because it conforms to our 1980 position, and addresses a very important issue: acknowledging, understanding, and acting on some of the vast range of knowledge we have gained in recent years about known, and suspected causes of cancer.

We do not expect to be able to totally eliminate workers' cancer risk as a result of enactment of this bill, or any other bill. We know, for example, that cigarette smoking dramatically enhances the carcinogenic effects of many toxic agents, and it is still unlikely that we will succeed in getting every smoker who works in a high-risk environment to quit smoking. Although that would be the ideal situation for dramatically reducing cancer among the high-risk workers.

However, we believe that the kind of monitoring and following up of workers at high risk that is proposed in this bill is reasonable; would not be a high cost item for employers; would

place the responsibility for action with the employee; and would, Mr. Chairman, have the potential for saving many thousands of lives from cancer.

The American Cancer Society has a special interest in the objectives of this legislation. Much of the information gained over the past 20 years about workplace carcinogens and other toxic substances has been realized through two of the Society's long-term studies, "The Environmental Cancer Research Project," and its "Cancer Prevention Study." They have provided the vital human epidemiological data regarding such substances as asbestos, vinyl chloride, kepone, PCB's and others.

We have gained a great deal of knowledge in the two past decades about the effects on humans of known and suspected carcinogens in the workplace. That was the first step. We now have an opportunity to take the necessary second step to put that new knowledge to work in saving the lives of the people who make this country function.

A review of S. 2050 suggests that it is an excellent vehicle to do this: it is fair, and it should be acceptable to both business and industry. Its purpose, as we interpret it, is to promote the prevention and early detection of occupational diseases through a system of identifying, notifying, and counseling workers at risk, while encouraging the facilities needed for expert diagnosis and treatement.

We already know what some of the hazardous substances are. In recent years, the Occupational Safety and Health Administration (OSHA) has issued permanent standards setting permissible

exposure limits for more than 20 toxic substances.

Six years ago, the American Cancer Society, called attention to the right of workers to be informed about carcinogenic substances to which they may be exposed in their workplace, when such knowledge exists. The Metzenbaum-Stafford legislation goes beyond our general suggestion of that time -- S. 2050 promises to be far more effective by focusing precisely on those workers who need the knowledge most, and those who are at highest risk by virtue of their exposure to the heaviest concentrations of toxic agents.

Current federal law provides that medical records be kept by employers for workers at high risk. Current law also requires that worker populations be advised through general notification -- such as notices on bulletin boards -- that they should monitor their conditions through their physicians, or other medical care and social service professionals. While we believe that the law is on the right track, it has not been as effective, precisely because it is general and not focused, as is S. 2050.

A key element of the bill is the proposed enhancing of regional health care centers where local health care professionals would be provided with training to do the actual surveillance of those persons at high risk.

Mr. Chairman, the American Cancer Society believes that S. 2050 is a good bill. As we interpret it, it recognizes the concerns of business and industry, while at the same time, would provide a vital new element in the lives of the American worker -- our greatest national, as well as natural resource.

The job of the American Cancer Society is to eliminate cancer through prevention, early diagnosis, service to the cancer patient, and research. While we claim no expertise in the area of compliance and regulation, we believe that enactment of this legislation would significantly reduce, over a period of time, both the incidence and death rate of cancer.

Thank you very much for the opportunity to appear before you. I would be pleased to answer any questions.

THE MOUNT SINAI MEDICAL CENTER
ONE GUSTAVE L. LEVY PLACE • NEW YORK, N.Y. 10029

Mount Sinai School of Medicine • The Mount Sinai Hospital

June 5, 1986

Ms Charlene Abshire
Committee on Labor and Human Resources
U.S. Senate
Washington, D.C. 20510

Dear Ms. Abshire:

John H. Madigan, Jr. of the American Cancer Society has forwarded to me several questions being asked by Senator Metzenbaum. I am happy to respond to them.

1. Can a notification program promote early intervention to prevent or successfully treat occupationally-related disease? Yes, but incompletely so. Better still would be avoidance of exposures, but this option is no longer available to us.

   Notification of asbestos hazards, for example, together with information concerning smoking, has resulted in personal protective measures being more widely used and--not everyone--many stopping smoking. This latter sharply decreases the risk of subsequent development of lung cancer since those who stop have approximately one-third the risk of dying of lung cancer compared to those who do not. Notification is the key. In addition, in some few cases, awareness of the potential hazard has resulted in early diagnosis and improved therapeutic results.

2. See above. There is no question of this.

3. Can we notify workers who have not been studied based on data available on workers who have been studied? Yes. Not every group has to undergo studies--they are perfectly well able to absorb and appreciate the experience of other groups. This is the basis of much public health practice.

4. Essentially, OSHA notifies, to the extent that it does, individuals and plants with regard to agents being used. Too, OSHA does not notify retired workers, nor those who have long since gone to another job, often the very ones who, with the passage of time, are at the greatest risk. S.2050 concentrates limited resources on those

that are at highest risk. OSHA does not have this perspective.

5. The American Mining Congress comment skirts the very important question of dose-disease response. Trivial amounts of silica do not result in extensive disease. While it will do no harm for everyone exposed to silica to be aware of this, still, insofar as disease prevention and treatment is concerned, concentrating notification on those with the heaviest exposure would have many advantages.

6. A 30% risk factor is defensible not only from a mathematical-statistical point of view (W.J. Nicholson) but conforms to advancing ideas on this question (see "Decision-making under uncertainty in the setting of environmental health regulations", J.M. Robins, P.J. Landrigan, P.J. Robins, L.J. Fine, Journal of Public Policy 3:322, 1985.)

I hope that this information will be of assistance to you.

Sincerely yours,

Irving J. Selikoff, M.D.
Professor Emeritus

IJS:jm
cc: Mr. John H. Madigan, Jr.

Senator METZENBAUM. Thank you very much, Dr. Selikoff. Your personal support as well as that of the American Cancer Society is very important to us. You certainly are well-renowned throughout the Nation as an expert in this field, and it pleases me much to have your support.

Dr. SELIKOFF. Thank you, sir.

Senator METZENBAUM. Dr. Finklea.

Dr. FINKLEA. Thank you, Senator.

I used to serve as the Director of the National Institute for Occupational Safety and Health before I returned to teaching at a medical school, and I had an opportunity to testify before this subcommittee on this issue 9 years ago. In fact, I believe the date was about May 9 or 10, 1977.

Your subcommittee asked our Institute to submit to you——

Senator METZENBAUM. Do you think we have made much progress since then, Dr. Finklea?

Dr. FINKLEA. Well, some.

Senator METZENBAUM. Some.

Dr. FINKLEA. I think we have made a lot of progress in one area. I think Mr. Tyson correctly said that the Hazard Communication Standard would be very, very helpful to workers currently employed and workers in the future, if it can be implemented across all of our society. I have my doubts that we will be able to really get that standard fully implemented in small workplaces and in those firms and workplaces not covered by the OSH Act.

Senator METZENBAUM. Do you think that the Government is in a better position to have the notification responsibility rather than the employers?

Dr. FINKLEA. I think the Government is in a very good position to supplement what OSHA should do as its primary job.

I think my old Institute [NIOSH] should have done a lot better job. When I was there, I came before you and told you that we had about 101,000 people in cohort mortality studies that had not been notified about their potential health risks; and you heard today you have some 240,000 such workers listed in their files. So we seem to have made the overall problem a little worse while we were doing the two pilot notification studies in that Institute.

Senator METZENBAUM. We are losing?

Dr. FINKLEA. We are getting a little further behind.

I might point out, too, that NIOSH submitted its recommendations to OSHA for a hazard identification system in 1974, and it is now 1986, and we are finally getting around to doing something about it. So I wish we had done a lot better job a lot sooner.

In my testimony, which I hope you will put in the record in its entirety——

Senator METZENBAUM. Yes. I might say the testimony of each of the witnesses will be included in the record in their entirety.

Dr. FINKLEA [continuing]. Thank you, Senator—I did enumerate several groups of workers that just do not seem to be covered very well now, from my standpoint, and I think these groups have been mentioned by other witnesses.

I would like to read the portion of my testimony that deals with my observations dealing with individual patients, if I could. It will not take very long, Mr. Chairman.

I think we really need a prevention-oriented health care system for people who have been exposed and are therefore at high risk, and I think your legislation will go a long way toward meeting this need.

Let me just give you these two or three examples. Some time ago, a medical resident asked me to see a patient in the VA hospital of our medical center. The patient had developed symptomatic coronary artery disease at a young age, even though the usual risk factors for early onset coronary disease were not present.

The patient informed me that he had worked in a churn room of a rayon production plant that had been closed several years previously. He told of 10 or more of his friends who worked at the same plant who experienced sudden death at an early age. To this day, the more than 100 former churnroom workers in this plant have not been informed regarding the nature or extent of their exposure to carbon disulfide, a solvent known to be associated with an increased risk for serious cardiovascular disease. These workers, many of whom probably live less than an hour's drive from a major medical center, have not been offered a prevention-oriented medical care program directed toward reducing the risk of cardiovascular disease and the early treatment of cardiovascular disease.

So that is another example of a group that would benefit from notification. In the written testimony which I submitted. I gave you the example of an individual who was exposed to a solvent, carbon disulfide, that certainly has the capability of producing cardiomyopathy, early onset atherosclerosis and some other complications.

Now, the Government has known about this carbon disulfide problem for a long time. This particular company knew about this exposure as a potential health problem probably only a year or two after they closed this plant. So these people could have been informed of their risk since then, and a number of them have died who did not have to die.

I will give another example here of a worker for a utility company who called up and said he wanted to come in because he said that five of the seven people who had held one of his old jobs had died of cancer. This particular worker was involved in testing the used fluid from transformers that had been heated up. I was also told of one fellow who worked in the same sort of job who short circuited the usual test methods by actually tasting the material. Later on, we found out that this material contains dioxins and dibenzofurans, which are very potent carcinogens. The point is that these people had never been notified by their employers about this problem, and I am not sure that the OSHA Hazard Communication Standard will require that they be notified about degradation products of the chemicals to which they are exposed. I do not think the Hazard Communication Standard will cover this.

I could give you a lot more examples. I would like to say, though, that the comments made about access under the regulations dealing with medical and exposure records are true in theory, but like many things, they are not true in practice. It reminded me of many of the jokes from eastern Europe, that deal with what is true in theory and what is true in practice. In practice, if you are a worker in a small plant, and you go asking questions, you will get fired. If you have got money to hire a lawyer to deal with this, maybe you

will win your case after a couple years, but that does not help you very much. So you do not usually get the information you need.

Even when I, as a physician, contact larger companies about exposure information and about material safety data sheets, I do not always get a quick or full reply.

Thank you.

[The prepared statement of Dr. Finklea and responses to questions subsequently submitted to him, follow:]

STATEMENT OF
DR. JOHN F. FINKLEA
PROFESSOR OF PREVENTIVE MEDICINE
SCHOOL OF MEDICINE
UNIVERSITY OF ALABAMA IN BIRMINGHAM

Before the

SUBCOMMITTEE ON LABOR
SENATE COMMITTEE ON LABOR AND HUMAN RESOURCES

MAY 15, 1986

MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE;

I AM DR. JOHN F. FINKLEA, PROFESSOR OF PREVENTIVE MEDICINE IN THE DEPARTMENT OF MEDICINE AT THE MEDICAL SCHOOL OF THE UNIVERSITY OF ALABAMA IN BIRMINGHAM. THE TEACHING PROGRAMS OF OUR DEPARTMENT INVOLVE MEDICAL STUDENTS, GRADUATE STUDENTS, AND RESIDENT PHYSICIANS. I ALSO HAVE RESPONSIBILITIES INVOLVING PATIENT CARE, COMMUNITY SERVICE, AND CONTINUING EDUCATION. PRIOR TO JOINING THE UNIVERSITY I WORKED FOR TEN YEARS AS A FEDERAL RESEARCH SCIENTIST AND AS A MANAGER OF RESEARCH PROGRAMS DEALING WITH EITHER ENVIRONMENTAL HEALTH OR OCCUPATIONAL SAFETY AND HEALTH. FROM APRIL 1975 UNTIL JANUARY 1978 MY FEDERAL ASSIGMENT WAS TO SERVE AS DIRECTOR OF THE NATIONAL INSTITUTE FOR OCCUPATIONAL SAFETY AND HEALTH (NIOSH).

I APPRECIATE THE INVITATION OF THE SUBCOMMITTEE TO PARTICIPATE IN YOUR HEARINGS ON S.2050, "THE HIGH RISK OCCUPATIONAL DISEASE NOTIFICATION AND PREVENTION ACT." I AM NOT TESTIFYING TODAY AS A REPRESENTATIVE OF MY UNIVERSITY BUT RATHER AS A PRIVATE CITIZEN WHOSE TESTIMONY IS BASED UPON PERSONAL KNOWLEDGE AND EXPERIENCE.

NINE YEARS AGO, IN MAY OF 1977, THIS SUBCOMMITTEE HELD OVERSIGHT HEARINGS ON THE OCCUPATIONAL SAFETY AND HEALTH ACT. AS DIRECTOR OF THE NATIONAL INSTITUTE FOR OCCUPATIONAL SAFETY AND HEALTH, YOU INVITED ME TO TESTIFY REGARDING CERTAIN ASPECTS OF THE NIOSH PROGRAM. AT THAT HEARING WE DISCUSSED SOME OF THE PROBLEMS WHICH ARE BEING ADDRESSED BY S.2050. DURING THE 1977 HEARINGS YOUR SUBCOMMITTEE REQUESTED THAT NIOSH SUBMIT A PAPER DEALING WITH SOME OF THE ISSUES BROUGHT UP DURING THE HEARINGS. THIS PAPER, TRANSMITTED IN JULY 1977, WAS ENTITLED, "THE RIGHT TO KNOW: PRACTICAL PROBLEMS AND POLICY ISSUES ARISING FROM EXPOSURES TO HAZARDOUS CHEMICAL AND PHYSICAL AGENTS IN THE WORKPLACE." I AM PLEASED THAT WE HAVE MADE AND ARE MAKING PROGRESS TOWARDS RESOLVING SOME OF THE PROBLEMS WHICH WERE DISCUSSED AT THAT TIME. OF PARTICULAR IMPORTANCE IN THIS REGARD IS THE HAZARD COMMUNICATION STANDARD PROMULGATED BY THE DEPARTMENT OF LABOR UNDER THE OCCUPATIONAL SAFETY AND HEALTH ACT. THIS STANDARD SHOULD BE MOST HELPFUL IN THAT CURRENT AND FUTURE EMPLOYERS AND EMPLOYEES WILL BE ASSURED BETTER ACCESS TO HELPFUL INFORMATION REGARDING THE CHEMICAL AND PHYSICAL PROPERTIES AND THE POTENTIAL TOXICITIES OF SUBSTANCES UTILIZED AT WORK. ANOTHER POSITIVE DEVELOPMENT HAS BEEN THE COMPLETION OF TWO PILOT WORKER NOTIFICATION PROJECTS FUNDED BY NIOSH.

I CONGRATULATE YOUR SUBCOMMITTEE IN HOLDING PUBLIC HEARINGS ON S.2050 WHICH ADDRESSES A NUMBER OF OTHER UNRESOLVED PROBLEMS THAT WERE IDENTIFIED BY THE NIOSH PAPER SUBMITTED TO YOU ALMOST NINE YEARS AGO. AMONG THESE PROBLEMS ARE THE FOLLOWING:

- DEFINING RESPONSIBILITY FOR INFORMING INDIVIDUAL WORKER PARTICIPANTS IN CERTAIN KINDS OF EPIDEMIOLOGIC STUDIES (COHORT MORTALITY STUDIES) REGARDING THE RESULTS OF THESE STUDIES AND THE IMPLICATIONS, IF ANY, FOR PERSONAL, PREVENTION-ORIENTED HEALTH CARE.
- ESTABLISHING A SYSTEM FOR IDENTIFYING, NOTIFYING, AND COUNSELING OTHER WORKERS THOUGHT TO BE AT INCREASED RISK FOR THE FUTURE DEVELOPMENT OF ADVERSE HEALTH EFFECTS ATTRIBUTABLE TO JOBSITE EXPOSURE.
- ADDRESSING POTENTIAL EMPLOYEE DISCRIMINATION PROBLEMS HAVING TO DO WITH JOB TRANSFER AND ELIGIBILITY FOR INSURANCE.
- FINANCING PREVENTIVE MEDICAL CARE THAT MAY BE DEEMED ADVISABLE AS A CONSEQUENCE OF JOBSITE EXPOSURES.
- POINTING OUT THE IMPORTANCE OF DISEASE PREVENTION AND HEALTH

MAINTENANCE ACTIVITIES AND RECOGNIZING THAT THESE MATTERS ARE NOT ALWAYS WELL ADDRESSED BY OUR CURRENT HEALTH CARE AND WORKER COMPENSATION SYSTEMS.

THE PROPOSED LEGISLATION CORRECTLY RECOGNIZES THAT IT WILL BE NECESSARY TO MAKE CAREFUL JUDGMENTS REGARDING WHICH EXPOSURES WARRANT NOTIFICATION AND TO ESTABLISH CLEAR PRIORITIES FOR NOTIFICATION EFFORTS. IN OTHER WORDS, WE MUST TAKE GREAT CARE NOT TO BE OVERWHELMED OR TO BE SUPERFICIAL.

A NUMBER OF INDIVIDUALS, WHILE SUPPORTING THE OVERALL OBJECTIVES OF THE PROPOSED LEGISLATION, OPPOSE ITS PASSAGE AS BEING UNNECESSARY. ONE ARGUMENT ADVANCED IS THAT THE OSHA HAZARD COMMUNCATION STANDARD WILL DEAL ADEQUATELY WITH THE NOTIFICATION ISSUE. I HOPE THAT MY COLLEAGUES WHO HOLD THIS VIEW PROVE CORRECT OVER THE LONG TERM, BUT IT IS APPROPRIATE FOR ME TO REMIND YOU THAT THE HAZARD COMMUNICATION STANDARD PROBABLY DOES NOT AND WILL NOT PROVIDE FOR NOTIFICATION TO THE FOLLOWING GROUPS OF WORKERS:

- WORKERS WHO HAVE RETIRED OR WHO ARE DISABLED,
- WORKERS LAID OFF AT PLANTS THAT HAVE BEEN PERMANENTLY SHUT DOWN,
- WORKERS WHO HAVE CHANGED JOBS AND WHO ARE NO LONGER EMPLOYED BY THE FIRM AT WHICH EXPOSURES TOOK PLACE,
- FARM WORKERS AND WORKERS IN SMALL BUSINESSES THAT ARE FOR PRACTICAL PURPOSES NOT COVERED BY OSHA ENFORCEMENT AND COMPLIANCE PROGRAMS AND
- WORKERS EMPLOYED BY STATE AND LOCAL GOVERNMENTS THAT ARE NOT COVERED BY STATE OSHA PLANS.

THE SITUATION IS SOMEWHAT DIFFERENT FOR WORKERS COVERED BY THE MINE SAFETY AND HEALTH ACT (MSHA). UNLIKE OSHA, MSHA HAS A REQUIREMENT FOR WORKER TRAINING IN SAFETY AND HEALTH. DESPITE THIS ADVANTAGE MY OWN INTERVIEWS WITH A LIMITED NUMBER OF PATIENTS WHO WERE FORMERLY EMPLOYED IN MINING AND QUARRYING LEAD ME TO BELIEVE THAT SUCH WORKERS ARE NOT ALWAYS FULLY INFORMED REGARDING POTENTIAL HEALTH HAZARDS. CURRENT MINERS AND QUARRYMEN MAY BE MUCH BETTER INFORMED THAN THOSE WHO WORKED IN THESE OCCUPATIONS IN YEARS PAST.

LET ME SHARE WITH YOU SOME OF MY EXPERIENCES DURING RECENT YEARS THAT CONVINCED ME OF THE CONTINUING NEED FOR A PREVENTION ORIENTED SYSTEM DIRECTED TOWARD IDENTIFYING, NOTIFYING, AND COUNSELING WORKERS WHO MAY HAVE BEEN EXPOSED AT WORK TO POTENTIALLY HAZARDOUS CHEMICALS OR PHYSICAL AGENTS.

SOMETIME AGO A MEDICAL RESIDENT ASKED ME TO SEE A PATIENT IN THE VETERAN'S ADMINISTRATION HOSPITAL WITHIN OUR MEDICAL CENTER. THE PATIENT HAD DEVELOPED SYMPTOMATIC CORONARY ARTERY DISEASE AT A YOUNG AGE EVEN THOUGH THE USUAL RISK FACTORS FOR EARLY ONSET CORONARY ARTERY DISEASE (i,e. CIGARETTE SMOKING, DIABETES MELLITUS, MARKED LIPID ABNORMALITIES, HYPERTENSION, OR A STRONG FAMILY HISTORY OF EARLY ONSET CORONARY HEART DISEASE) WERE NOT PRESENT. THE PATIENT INFORMED ME THAT HE HAD WORKED IN THE CHURN ROOM OF A RAYON PRODUCTION PLANT THAT HAD BEEN CLOSED SEVERAL YEARS PREVIOUSLY. HE TOLD OF TEN OR MORE OF HIS FRIENDS WHO WORKED AT THE SAME PLANT AND WHO EXPERIENCED SUDDEN DEATH AT AN EARLY AGE. TO THIS DAY, THE MORE THAN 100 FORMER CHURN ROOM WORKERS AT THIS PLANT HAVE NOT BEEN INFORMED REGARDING THE NATURE OR EXTENT OF THEIR EXPOSURE TO CARBON DISULFIDE, A SOLVENT KNOWN TO BE ASSOCIATED WITH AN INCREASED RISK FOR SERIOUS CARDIOVASCULAR DISEASE. THESE WORKERS, MANY OF WHO PROBABLY LIVE LESS THAN AN HOUR'S DRIVE FROM A MAJOR MEDICAL CENTER, HAVE NOT BEEN OFFERED A PREVENTION ORIENTED MEDICAL CARE PROGRAM DIRECTED TOWARDS REDUCING THE RISK FOR CARDIOVASCULAR DISEASE AND THE EARLY TREATMENT OF CARIDIOVASCULAR DISEASE.

I WAS MORE RECENTLY ASKED TO SEE ANOTHER PATIENT, A FOREMAN FROM ANOTHER PLANT, WHO WAS VERY ILL WITH CARDIOMYOPATHY. THIS MAN WAS PHYSICALLY DISABLED. HE ESPECIALLY REGRETTED THAT HE COULD NO LONGER LEAD THE SINGING IN HIS SMALL CHURCH OR TEACH SUNDAY SCHOOL. THESE WERE ACTIVITIES THAT HAD MEANT A GREAT DEAL TO HIM. HIS JOB ENTAILED EXPOSURES TO BOTH CARBON DISULFIDE AND ANOTHER TOXIC CHLORINATED ORGANIC SOLVENT. HE HAD NEVER BEEN INFORMED REGARDING THE POTENTIAL TOXICITIES OF THESE AGENTS. INDEED, HE HAD BEEN RETURNED TO WORK AND EXPERIENCED ADDITIONAL EXPOSURES FOR AN EXTENDED PERIOD AFTER THE INITIAL DIAGNOSIS OF HIS CARDIOMYOPATHY. HIS CONDITION CONTINUED TO DETERIORATE, PROBABLY IN PART BECAUSE OF CONTINUED EXPOSURES. WHEN I LAST SAW HIM, THERE APPEARED TO BE VERY LITTLE MORE THAT COULD BE DONE AND HIS PROGNOSIS WAS NOT GOOD.

NOT LONG AGO A WORKER FOR A UTILITY COMPANY ASKED FOR AN APPOINTMENT BECAUSE HE WAS WORRIED ABOUT GETTING CANCER. I ASKED HIM WHY HE WAS CONCERNED AND HE TOLD ME HE WAS CONCERNED BECAUSE FIVE OF THE SEVEN MEN WHO HAD PREVIOUSLY HELD ONE OF HIS PAST JOBS HAD DIED OF CANCER, SOME AT A YOUNG AGE. THIS JOB INVOLVED TESTING FLUIDS REMOVED FROM TRANSFORMERS AND OTHER ELECTRICAL EQUIPMENT AFTER FIRES OR OVERHEATING TO ASCERTAIN WHETHER OR NOT THIS FLUID COULD BE REUSED. I WAS TOLD OF ONE MAN WHO DID NOT CHOOSE TO USE THE RECOMMENDED TEST METHOD BUT INSTEAD FELT HE COULD MAKE AN ACCURATE DETERMINATION BY TASTING THE BURNT FLUID. HE IS SAID TO HAVE DEVELOPED AN UNUSUAL MALIGNANCY THAT HAS BEEN LINKED TO DIOXIN EXPOSURE. MY PATIENT AND HIS CO-WORKERS HAD NOT BEEN INFORMED REGARDING THE POTENTIAL TOXICITY OF POLYCHLORINATED BIPHENYLS OR THEIR MORE TOXIC THERMAL DEGRADATION PRODUCTS THE DIOXINS AND THE POLYCHLORINATED DIBENZOFURANS.

THERE ARE MANY MORE EXAMPLES I COULD GIVE TO YOU INVOLVING CURRENT AND FORMER WORKERS WHO HAVE NOT BEEN INFORMED THAT THEY WERE EXPOSED TO A VARIETY OF TOXIC SUBSTANCES INCLUDING LEAD, ASBESTOS, SILICA FLOUR, INORGANIC ARSENIC, PETROLEUM SOLVENTS, AND OTHER AGENTS. THESE AGENTS ARE CAPABLE OF INCREASING THE RISK FOR A VARIETY OF CHRONIC DISEASES INCLUDING CANCERS OF SEVERAL DIFFERENT TYPES, KIDNEY IMPAIRMENT, CHRONIC RESPIRATORY DISEASE, NEUROLOGIC DISORDERS AND LIVER DYSFUNCTION.

INDIVIDUALS AND GROUPS OPPOSED TO THIS LEGISLATION AS BEING UNNECESSARY HAVE EXPRESSED THE VIEW THAT CURRENT AND FORMER EMPLOYEES ARE ALREADY PROVIDED ACCESS TO RELEVANT EXPOSURE AND MEDICAL RECORDS BY OSHA REGULATION. I HAVE ALREADY POINTED OUT THAT MANY WORKERS ARE NOT COVERED BY OSHA COMPLIANCE PROGRAMS AND THEREFORE ARE NOT GUARANTEED ACCESS TO RELEVANT RECORDS. EVEN FOR WORKERS COVERED BY THE OSHA STANDARD DEALING WITH ACCESS TO EMPLOYEE EXPOSURE AND MEDICAL RECORDS, ACCESSIBILITY IS NOT A MATTER OF ROUTINE. WHERE THERE ARE WELL-ESTABLISHED OCCUPATIONAL SAFETY AND HEALTH PROGRAMS WITH APPROPRIATE CORPORATE POLICY SUPPORT, ADEQUATE PROFESSIONAL STAFFING AND STRONG WORKER PARTICIPATION, WORKER ACCESS TO MEDICAL AND EXPOSURE RECORDS MAY NO LONGER BE A PROBLEM. UNFORTUNATELY, MANY WORKSITES DON'T HAVE THAT KIND OF OCCUPATIONAL SAFETY AND HEALTH PROGRAM. IN THESE CASES ACCESS IS MADE DIFFICULT AND WORKERS STILL FEAR THAT REQUESTING SUCH INFORMATION MAY LEAD TO LATER JOB LOSS. HIRING AN ATTORNEY TO HELP THEM WITH ACCESS IS EXPENSIVE AND REALLY SHOULDN'T BE NECESSARY. MOST ORDINARY PEOPLE I SEE CANNOT AFFORD TO EXERCISE THEIR RIGHT OF ACCESS. AS A PHYSICIAN, I HAVE CALLED OR WRITTEN MANY COMPANIES REGARDING EXPOSURE INFORMATION. SOME ARE COOPERATIVE, MANY ARE NOT. REQUESTS FOR EXPOSURE INFORMATION ARE SOMETIMES REFERRED TO COMPANY ATTORNEYS WHO RESPOND WITH A LONG SERIES OF HARASSING QUESTIONS ABOUT THE

PATIENT WHICH AN ETHICAL PHYSICIAN SHOULD NOT ANSWER WITHOUT AUTHORIZATION BY THE PATIENT.

WHILE THERE MAY BE MANY CRITICISMS OF THE SYSTEM FOR IDENTIFYING, NOTIFYING AND COUNSELING WORKERS WHICH IS CALLED FOR IN S.2050, NO ONE HAS TO MY KNOWLEDGE YET PROPOSED A BETTER, MORE WORKABLE SYSTEM FOR DEALING WITH THESE ISSUES. FOR THAT REASON I STRONGLY SUPPORT THIS BILL. I WOULD LIKE TO OFFER SOME SPECIFIC COMMENTS AND SUGGESTIONS ON SOME OF THE PROVISIONS OF THE BILL.

THE INDIVIDUALS WHO DRAFTED S.2050 WERE FACED WITH THE PROBLEM OF HOW TO DEFINE THE TERM "POPULATION AT RISK". THIS IS NOT AN EASY TASK TO ACCOMPLISH IN A MANNER THAT IS GENERALLY ACCEPTABLE TO ALL OF THOSE INTERESTED IN OCCUPATIONAL SAFETY AND HEALTH. I HAVE AN UNDERSTANDING OF HOW THE CURRENT DEFINITION WAS DEVELOPED. I ALSO UNDERSTAND OBJECTIONS WHICH HAVE BEEN RAISED REGARDING THE USE OF THE PROPOSED DEFINITION, I.E. "AN EMPLOYEE POPULATION EXPOSED TO HAZARDOUS OCCUPATIONAL EXPOSURES WITHIN WHICH AN ASSOCIATED DISEASE OCCURS AT A RATE 30 PER CENT GREATER THAN A COMPARABLE POPULATION NOT EXPOSED TO THE HAZARDOUS OCCUPATIONAL EXPOSURE." IT IS MY UNDERSTANDING THAT NIOSH HAS ASKED A SUBCOMMITTEE OF ITS BOARD OF SCIENTIFIC COUNSELORS TO CONSIDER THIS PROBLEM. I WOULD URGE THE SUBCOMMITTEE TO ASK NIOSH TO MAKE THE REPORT OF THEIR COUNSELORS AVAILABLE FOR YOUR CONSIDERATION. MY OWN OPINION IS THAT YOUR DEFINITION SHOULD TAKE COGNIZANCE OF THE NEED FOR ADEQUATELY DESIGNED STUDIES, STATISTICAL SIGNIFICANCE OF ANY PERCEIVED EXCESS RISK, ADJUSTMENT FOR CONFOUNDING OR INTERFERING FACTORS AND ABSOLUTE LIFETIME RISK ATTRIBUTED TO JOBSITE EXPOSURE. MY PERSONAL FEELING IS THAT AN EXCESS RISK OF LESS THAN 30 PER CENT MIGHT WARRANT NOTIFICATION IN SOME CIRCUMSTANCES, AS WITH CARDIOVASCULAR DISEASE MORBIDITY/MORTALITY OR OTHER COMMON CHRONIC DISEASE PROBLEMS.

MY GENERAL INCLINATION IS TO OPPOSE THE FURTHER PROLIFERATION OF FEDERAL BOARDS AND ADVISORY GROUPS. ON THE OTHER HAND I AGREE THAT IT IS NECESSARY TO HAVE A GROUP THAT COULD REVIEW SCIENTIFIC STUDIES AND ESTABLISH PRIORITIES FOR NOTIFICATION. SINCE THE FEDERAL STUDIES BEING REVIEWED ARE MOST LIKELY TO HAVE BEEN CONDUCTED BY THE CENTERS FOR DISEASE CONTROL OR THE NATIONAL INSTITUTES OF HEALTH, IT IS APPROPRIATE THAT THIS REVIEW BE DONE AT THE LEVEL OF THE ASSISTANT SECRETARY FOR HEALTH RATHER THAN BY ONE OF THE AGENCIES OR INSTITUTES CONDUCTING THE STUDIES. AN ALTERNATIVE TO A NEW SEPARATE RISK ASSESSMENT BOARD MIGHT BE TO HAVE THE FUNCTIONS ENUMERATED FOR THE BOARD ASSIGNED AS A RESPONSIBILITY OF AN EXISTING GROUP SUCH AS THE COMMITTEE TO COORDINATE ENVIRONMENTALLY RELATED PROGRAMS (CCERP). CCERP IS AN ALREADY CHARTED AND FUNCTIONING GROUP COMPOSED OF GOVERNMENTAL SCIENTISTS. ITS CHAIRMAN REPORTS TO THE ASSISTANT SECRETARY FOR HEALTH. TAKING ADVANTAGE OF A WELL ESTABLISHED COORDINATING MECHANISM MIGHT ASSURE THAT THOSE RESPONSIBLE FOR THE RISK ASSESSMENT FUNCTION CAN READILY ACCESS NEEDED EXPERTISE WITHIN ANY OF THE AGENCIES REPORTING TO THE ASSISTANT SECRETARY FOR HEALTH. ON THE OTHER HAND, ASSIGNING THE FUNCTIONS OF THE RISK ASSESSMENT BOARD TO CCERP OR ANOTHER EXISTING GROUP COULD BE A DISADVANTAGE IN THAT THE EFFORTS OF THE ADVISORY GROUP MIGHT BE DILUTED AND NOT BE CLEARLY FOCUSED ON THE FUNCTIONS OUTLINED IN SECTION 4 OF S.2050.

TO SOME EXTENT I AM DISAPPOINTED IN THAT THE PROPOSED LEGISLATION DOESN'T SEEM TO ENCOURAGE, PERSUADE, OR REQUIRE FEDERAL AGENCIES CONDUCTING MORBIDITY OR MORTALITY STUDIES INVOLVING OCCUPATIONAL COHORTS TO ENSURE THAT MEMBERS OF

SUCH COHORTS OR THEIR SURVIVORS HAVE ACCESS TO THE RESULTS OF SUCH STUDIES. THE RESEARCH AGENCIES CONDUCTING SUCH STUDIES MAY NOT BE ABLE TO ACCOMPLISH THIS KIND OF NOTIFICATION FOR ALL PRIOR STUDIES INVOLVING OCCUPATIONAL COHORTS BUT THEY CAN BUILD THIS INTO FUTURE STUDIES AT LITTLE ADDITIONAL COST. SUCH A POLICY IS CERTAINLY CONSISTENT WITH THE INFORMATION PROVIDED TO PARTICIPANTS IN OTHER WORKPLACE AND CLINICAL STUDIES. FAILURE TO DO THIS WILL IN MY OPINION HAVE THE TENDENCY IN THE LONG RUN TO UNDERMINE THE CREDIBILITY OF THE FEDERAL RESEARCH GROUPS AND TO REINFORCE THE SOMETIMES HEARD OPINION THAT RESEARCHERS CONDUCTING SUCH STUDIES ARE ELITISTS HAVING LITTLE INTEREST IN THE HEALTH WELFARE AND RIGHTS OF INDIVIDUAL WORKERS WHO MAKE UP THE COHORTS AND PAY FOR THE STUDIES WITH THEIR HARD EARNED TAX DOLLARS.

I WOULD NOW LIKE TO COMMENT ON THE SECTION DEALING WITH SETTING PRIORITIES FOR THE RISK ASSESSMENT BOARD(SECTION 4c). THE PROPOSED LEGISLATION REQUIRES THAT THE BOARD REVIEW EMPLOYEE POPULATIONS EXPOSED TO HAZARDOUS OCCUPATIONAL EXPOSURES FOR WHICH THERE EXISTS A PERMANENT OSHA STANDARD AS ITS FIRST PRIORITY AND THAT THE FINDINGS AND RECOMMENDATIONS ON NO LESS THAN FIVE EMPLOYEE POPULATIONS SHALL BE TRANSMITTED TO THE SECRETARY WITHIN ONE YEAR FROM THE EFFECTIVE DATE OF THE PROPOSED LEGISLATION. IN MY OPINION THERE SHOULD BE A REQUIREMENT THAT RECOMMENDATIONS OF THE BOARD DEAL WITH NO LESS THAN FIVE EMPLOYEE POPULATIONS EACH YEAR DURING THE PERIOD WHEN FUNDS ARE AUTHORIZED TO BE APPROPRIATED TO CARRY OUT THE PURPOSES OF THE LEGISLATION. OTHERWISE, YOU MAY HAVE A BOARD THAT MAKES NO RECOMMENDATIONS AFTER THE FIRST YEAR. DO NOT UNDERESTIMATE THE TENDENCY TO DELAY AND PONDER. IT SHOULD ALSO BE MADE CLEAR WHAT CONSTITUTES AN "EMPLOYEE POPULATION". DOES THIS REFER TO WORKERS EXPOSED TO AN AGENT OR A DEFINED PROCESS OR COULD THIS BE CONSTRUED AS THE EMPLOYEES IN A SINGLE JOB ASSIGNMENT AT ONE PLANT? WHILE THE DEFINITION DOES NOT NOW MAKE ANY REFERENCE TO THE INTENSITY OR DURATION OF EXPOSURE, IT DOES NOT PRECLUDE THE RISK ASSESSMENT BOARD FROM CONSIDERING SUCH ASPECTS.

WITH REGARD TO PRIORITIES, IT IS IMPORTANT TO REMEMBER THAT THE EXISTING OSHA PERMANENT STANDARDS DO NOT NECESSARILY DEAL WITH EXPOSURES OF THE GREATEST IMPORTANCE TO WORKER HEALTH. THE STANDARDS FOR THE MOST PART REFLECT WHAT CONCERNED, WELL ORGANIZED WORKER GROUPS AND PUBLIC INTEREST ORGANIZATIONS HAVE BEEN ABLE TO PUSH THROUGH RULE MAKING AND SUBSEQUENT LEGAL CHALLENGES. FROM A HEALTH POINT OF VIEW THE BOARD MIGHT, WITH GOOD REASON, DESIRE AS ITS FIRST PRIORITY TO MAKE RECOMMENDATIONS DEALING WITH AN EXPOSURE FOR WHICH THERE IS NOT A PERMANENT STANDARD. SUCH AN EXPOSURE MIGHT BE MORE OF A PROBLEM AT SMALL WORKSITES THAT ARE UNDERSERVED BY EXISTING FEDERAL AND EMPLOYER OCCUPATIONAL HEALTH PROGRAMS. ON THE OTHER HAND, IT IS LIKELY THAT ANY HIGH PRIORITY PROBLEM FOR WHICH THERE IS NOT YET A PERMANENT OSHA STANDARD WILL HAVE BEEN CONSIDERED BY OTHER FEDERAL GROUPS OR BY INTERNATIONAL AGENCIES WHICH REVIEW OCCUPATIONAL HEALTH EXPOSURE AND TOXIC SUBSTANCES PROBLEMS. FOR THAT REASON I RECOMMEND THAT THE PRIORITY SECTION BE AUGMENTED, ADVISING THE BOARD TO ALSO GIVE PRIORITY TO THOSE SUBSTANCES, GROUPS OF SUBSTANCES, AND TECHNOLOGICAL OR MANUFACTURING PROCESSES CLASSIFIED BY OUR NATIONAL TOXICOLOGY PROGRAM AS KNOWN TO BE CARCINOGENIC OR REASONABLY ANTICIPATED TO BE CARCINOGENIC. THE BOARD SHOULD ALSO BE ASKED TO REVIEW DETERMINATIONS MADE BY THE INTERNATIONAL AGENCY FOR RESEARCH ON CANCER OF THE WORLD HEALTH ORGANIZATION (IARC/WHO) AND THE DETERMINATIONS AND RECOMMENDATIONS MADE THROUGH THE CRITERIA DOCUMENTS OF THE OFFICE OF OCCUPATIONAL HEALTH OF THE WORLD HEALTH ORGANIZATION (OH/WHO). THE BOARD SHOULD BE ENCOURAGED EARLY ON TO SOLICIT SUGGESTIONS REGARDING ITS PRIORITIES FROM PROFESSIONAL GROUPS

ACTIVE IN OCCUPATIONAL SAFETY AND HEALTH, FROM AGENCIES OR INSTITUTES ACTIVE IN OCCUPATIONAL RESEARCH, FROM WORKER ORGANIZATIONS, AND FROM EMPLOYERS OR THEIR ASSOCIATIONS.

SECTION 5 DEALING WITH NOTIFICATION AND COUNSELING SHOULD BE ALTERED TO ALLOW THE SECRETARY TO CONDUCT PHASED NOTIFICATION WHEN THAT SEEMS ADVISABLE. A PILOT STUDY MAY BE NECESSARY BEFORE SETTLING UPON THE FINAL CONTENT OF THE NOTIFICATION PACKAGE. LIKEWISE, EXPERIENCE MAY DICTATE CHANGES IN THE ADVICE GIVEN TO HEALTH PROVIDERS AND INDIVIDUALS. ALLOWING PHASED NOTIFICATION WOULD IN MY OPINION IMPROVE THE EFFECTIVENESS OF THE PROPOSED LEGISLATION.

SECTION 5 ALSO MENTIONS THE ROLE OF STATE AND LOCAL HEALTH DEPARTMENTS. A MAJOR ROLE FOR STATE AND LOCAL HEALTH DEPARTMENTS SEEMS NECESSARY IF NEEDED SERVICES ARE TO BE PROVIDED FOR WORKERS UNDERSERVED BY EMPLOYER OCCUPATIONAL SAFETY AND HEALTH PROGRAMS AND NOT NOW COVERED BY OSHA. THE EXPERTISE OF HEALTH DEPARTMENTS WILL BE MOST HELPFUL IN IDENTIFYING WORKERS TO BE NOTIFIED AND IN PROVIDING ACCESSIBLE SERVICES.

TURNING TO SECTION 6 OF THE ACT, I WOULD LIKE TO SEE SECTION 6(A) ALTERED SO THAT ALL ACADEMIC MEDICAL CENTERS AND TEACHING HOSPITALS WOULD BE ELIGIBLE TO APPLY TO BECOME CERTIFIED AS OCCUPATIONAL AND ENVIRONMENTAL HEALTH CENTERS. IN MY OPINION ENCOURAGING COMPETITION AMONG THESE INSTITUTIONS WOULD BE IN THE PUBLIC INTEREST. AS CURRENTLY WRITTEN SECTION 6 SEEMS TO FAVOR A LIMITED NUMBER OF INSTITUTIONS AND THAT DOESN'T SEEM TO BE GOOD PUBLIC POLICY.

THE PROVISIONS IN SECTION 7 OF THE PROPOSED LEGISLATION DEALING WITH RESEARCH, TRAINING AND EDUCATION ARE VERY MUCH NEEDED. THE KINDS OF RESEARCH MENTIONED HAVE NOT BEEN GIVEN HIGH PRIORITY BY INSTITUTES AND AGENCIES OPERATING UNDER EXISTING LEGISLATIVE MANDATES. I WOULD FURTHER SUGGEST THAT THE RESEARCH PROGRAMS ALREADY ENUMERATED IN S.2050 BE AUGMENTED BY CALLING FOR THE DEVELOPMENT OF CONSENSUS RECOMMENDATIONS FOR PREVENTION ORIENTED MEDICAL CARE FOR WORKERS THOUGHT TO BE AT INCREASED RISK AND REQUESTING STUDIES TO EVALUATE THE PREVENTION-ORIENTED OCCUPATIONAL HEALTH SERVICES CALLED FOR BY THIS LEGISLATION. THE AVAILABILITY, ACCESSIBILITY, QUALITY AND EFFECTIVENESS OF SUCH CARE SHOULD BE CONSIDERED IN EVALUATIONS.

SECTION 8 OF THE PROPOSED LEGISLATION DEALS WITH TWO PROBLEMS THAT WERE FORESEEN AS A POSSIBLE COMPLICATION OF NOTIFICATION, NAMELY THE NEED FOR SOME PROVISION DEALING WITH JOB TRANSFER AND THE NEED TO PROVIDE FUNDING FOR A PREVENTION-ORIENTED PERSONAL HEALTH CARE APPROACH AS PART OF THE HEALTH CARE SYSTEM. MY OWN OPINION IS THE WORKER COMPENSATION SYSTEMS AS NOW STRUCTURED SHOULD NOT BE EXPECTED TO ACCOMPLISH THE LATTER TASK. I FULLY UNDERSTAND THE RELUCTANCE OF INSURERS WHO PROVIDE FAMILY HEALTH INSURANCE TO HAVE THIS KIND OF CARE MANDATED. IT SHOULD BE POINTED OUT THAT THIS CARE MAY ALREADY BE COVERED BY SOME EXISTING POLICIES AND THAT SOME OF THE NEEDED SERVICES ARE ALREADY BEING PROVIDED AND PAID FOR BY POLICIES THAT DO NOT PROVIDE FOR SUCH CARE, USUALLY DISGUISED AS CARE FOR A NON-OCCUPATIONAL PROBLEM. IT SHOULD BE MENTIONED THAT THE HEALTH INSURANCE PROVISIONS OF THIS ACT MAY IN THE LONG RUN PROVIDE AN IMPORTANT INFORMATION BASE FOR BETTER SURVEILLANCE OF OCCUPATIONAL DISEASE AND ASSESMENT OF THAT PORTION OF THE CHRONIC DISEASE BURDEN ATTRIBUTABLE TO OCCUPATIONAL EXPOSURES. CURRENT OCCUPATIONAL DISEASE SURVEILLANCE EFFORTS HAVEN'T BEEN VERY SATISFACTORY.

IN SUMMARY, MR. CHAIRMAN, I STRONGLY SUPPORT S.2050 AND URGE THAT THE SUBCOMMITTEE MOVE FORWARD WITH LEGISLATION DIRECTED TOWARDS ESTABLISHING A SYSTEM FOR THE EARLY DETECTION AND PREVENTION OF OCCUPATIONAL AND WORK RELATED DISEASES THROUGH A WORKABLE SYSTEM OF IDENTIFYING, NOTIFYING, AND COUNSELING WORKERS AT RISK.

THIS CONCLUDES MY PREPARED STATEMENT, MR. CHAIRMAN. I WILL BE HAPPY TO ANSWER ANY QUESTIONS YOU OR MEMBER OF THE SUBCOMMITTEE MAY HAVE.

The University of Alabama at Birmingham
School of Medicine
Department of Medicine
Division of General and Preventive Medicine
205/934-2294, 205/934-4873

June 5, 1986

Charlene Abshire
Executive Assistant
Subcommittee on Labor
Committee on Labor and Human Resources
United States Senate
Washington, DC 20510

Dear Ms. Abshire:

Attached to this note you will find my comments on the questions which you submitted to me as a result of your hearings of May 15, 1986 dealing with S.2050, the High Risk Occupational Disease Notification and Prevention Act. If I can provide you any further information which you may need, please do not hesitate to contact me.

Sincerely yours,

John F. Finklea, M.D.

JFF/sws

Attachments

QUESTIONS FOR DRS. SELIKOFF, FINKLEA, ASHFORD

Question 1: In your experience, can a notification program promote early medical intervention to prevent or successfully treat occupationally-related disease?

Answer to Question 1: A notification program may change employer or worker behavior in ways that can prevent disease or modify the course of disease. I have seen several hundred maintenance workers employed by a number of different firms in buildings that contain sprayed on insulation materials. The employers involved simultaneously informed their workers about the possible health hazards associated with asbestos exposure, offered medical examination programs and offered smoking cessation programs. Workers were certified for the use of appropriate personal protective equipment which might be needed in the course of their duties. While these programs have not been inexpensive, they have resulted in a decreased exposure to asbestos and in changes of lifestyle, most appropriately smoking cessation. Perhaps the best example of notification and early medical intervention in preventing disease in our state has been the experience of the textile industry where workers identified as being especially susceptible to low levels of cotton dust are transferred to jobs not involving full exposure to cotton dust. By and large, such workers do not experience progressive loss of lung function attributable to cotton dust. It is also my belief that we can successfully intervene in other groups of workers in our state that have been exposed to agents which may increase the risk for chronic disease. In my testimony, I mentioned a group of workers exposed to carbon disulfide who are thought to be at increased risk for early onset coronary artery disease.

Question 2: In your experience, can notification serve as a catalyst to change workers' personal health habits?

Answer to Question 2: Yes, a number of our maintenance men have stopped smoking as a result of the asbestos notification project. For notification to be a successful catalyst, it is probably most helpful if intervention programs are readily available within the community. Such programs might deal with smoking cessation, nutrition and physical activity.

Question 3: Is it practical to talk about notifying workes who have not been studied based on the data available on workers who have been studied?

Answer to Question 3: Yes. There are many factors that will need to be considered in such a decision, including what is known about jobsite exposures, the characteristics of the processes utilized at the plants in which the workers are employed and the characteristics of the workers themselves. I would assume that defining which groups of workers should be notified would be one of the principle tasks of the board called for by the proposed legislation.

Question 4: Since OSHA has major responsibilities in the area of worker health, why not rely on OSHA to provide the notification called for under S.2050?

Answer to Question 4: As pointed out in previous submissions to the committee and during your hearing, notification may involve groups of workers not now covered under the Occupational Safety and Health Act. Furthermore, notification is likely to be

targeted on groups that have experienced exposures which are likely to result in disorders that can be prevented or ameliorated by intervention efforts. One would like to see notification incorporated into a prevention-oriented, personal health care system. It is my opinion that the components of a prevention-oriented, personal health care system would relate better to the Department of Health and Human Services than to the Department of Labor. For example, I would think it would be difficult for the Department of Labor to develop prevention oriented medical guidelines for a diverse group of disorders that might include certain malignancies, chronic respiratory diseases, cardiovascular disease and certain neurological conditions. The proposed legislation also calls for a number of kinds of needed health related research. It would seem to me that it would be difficult for the Department of Labor to develop the appropriate review mechanisms for research applications dealing with health problems. Placing the notification effort in the Department of Health and Human Services would have the further advantage of allowing better coordination of research funded under legislation dealing with notification and biomedical research carried out by that department and funded under other mandate. Notification may also require the assistance of State and Local Health Departments. Such assistance can best be assured through the cooperative links already established between State and Local agencies and the Department of Health and Human Services at the Federal level. It should also be mentioned that one of the notification mechanisms most suitable for retired persons might be through the Social Security Administration which is a part of the Department Health and Human Services. For all these reasons, it is my belief that the notification efforts should be placed within the Department of Health and Human Services. Let me hasten to add, however, that if a determination is made that the notification effort cannot be placed in the Department of Health and Human Services I would not object to its being placed elsewhere in the federal government.

Question 5; How do you answer the American Mining Congress concern that because almost all mining production employees are exposed to some form of silica dust, all would have to be notified?

Answer to Question 5: The board called for by the legislation would need to consider what information may exist on the frequency and extent of exposure in making a determination as to which worker groups should be notified. As a occupational physician, I would hope that all current mine and quarry workers exposed to levels of free silica that exceed the recommended action level (one-half of the permissible exposure limit) would already have been informed about their exposures. I would not think that the board would recommend that workers exposed to silica levels less than the action level should be notified. Sadly, my own experience leads me to believe that workers covered by mine safety and health legislation have not always been notified that they are experiencing levels of exposure to free silica that exceed permissable exposure limits. These elevated exposures are capable of causing silicosis. If the proposed legislation resulted in all such workers at risk finding out about their current or past excessive exposures to free silica, it would be worthwhile.

Question 6: Is the 30% risk factor defensible in medical or scientific terms?

Answer to Question 6: My own opinion is that the legislation or your report language should take into consideration things other than a perceived excess of 30%. These factors include the need for adequately designed studies (epidemiological, clinical and

toxicologic) statistical significance of any perceived excess risk, adjustment for confounding or interfering of factors and absolute lifetime risk attributed to jobsite exposure. My personal feeling is that an excess risk of less than 30% might warrant notification in some circumstances, as with cardiovascular disease morbidity and mortality or other common chronic disease problems. It is my understanding that NIOSH has asked a subcommittee of its Board of Scientific Counselors to consider the "population at risk" definition problem. I would urge the subcommittee to ask NIOSH to make the report of their scientific counselors available for your consideration. My answer to your question does not completely support the idea that a current perceived excess risk of 30% should always define the population at risk. I do agree with the need to establish such a definition in the legislation, however, and I do not think this is an insurmountable problem.

Senator METZENBAUM. Dr. Finklea, do you support S. 2050?

Dr. FINKLEA. Oh, yes.

Senator METZENBAUM. Thank you very much. You were the head of OSHA, appointed by——

Dr. FINKLEA. Oh, no, not OSHA; NIOSH.

Senator METZENBAUM. NIOSH. All right. You were head of NIOSH under—appointed by——

Dr. FINKLEA. I was appointed by Mr. Ford's administration and then served for a while under Mr. Carter, until Dr. Robbins came in.

Senator METZENBAUM. I just wanted my chairman to know that you had been President Ford's appointee. Maybe I can prevail upon him. Maybe that will soften him up a little bit.

Thank you. Let us hear from Dr. Ashford. Obviously, the Chairman has returned.

Dr. ASHFORD. Thank you very much.

I represent the American Public Health Association today in my comments. It might be interesting to my testimony that I am trained both as a lawyer and a chemist, and both of those are concerned with the questions reflected in this bill.

I am the former chairman of the National Advisory Committee on Occupational Safety and Health. I served first as a public member in the Ford administration and then in the Carter administration, helped Secretary Dunlop reconstitute OSHA after President Nixon left office, and no longer have any connection with the Department.

I would like to submit my testimony for the record, plus some key publications which I think you may find interesting relevant to this proceeding.

I believe fairness dictates that in addition to being informed through Federal and local right-to-know laws about the identity and the known health effects of exposure to toxic substances, workers also need to be informed about their health status. This includes both individually relative information and information relevant to their membership in a class of workers at risk. The information is crucial if workers are to be able to take timely remedial medical action to protect their health, to exercise self-help actions to decrease harmful exposures—for example, by exercising the right to refuse hazardous work, or to counter and discourage discriminatory actions on the part of employers and health care providers or insurers.

Let me make it clear, because questions have followed this line by Senator Kennedy and Senator Nickles, that neither the OSH Act, in my view, nor the regulations issued under this act, such as the hazard communication standard or the medical access rule, provide adequate informtion to or adequate avenues for relief to the worker. Only a few standards issued under section b(5) of the act provide for in fact adequate medical surveillance, and this medical surveillance does not amount to epidemiological studies, and there are real problems in including statistical significance with the information which is requested.

In addition, for none of the chemicals, absolutely none, regulated through the approximately 450 threshold limit values, which is the majority of chemicals to which workers are exposed, is medical sur-

veillance required. The OSHA Hazard Communication Standard requires transmission to current workers only, and without regard to the chemical identity and known health effects, there was a study published, but it does not transmit information of personalized or group-specific measures of health status.

The OSHA Medical Access Rule requires that employers provide workers access to health information; it does not require employers or the Government to transmit vital health information to workers unless they request it.

The right to access is not equivalent to the employer's duty to inform. And you have touched on that issue, and I want to emphasize it. In order to request information, workers must know that it exists, and that is why the proposed legislation is crucial.

The proposed legislation, in my view, could go further than it does. It does not adequately address the issue of individual risk. Yet there is great activity now in clinical and laboratory techniques for human monitoring, the so-called "biologic markers" movement, which focuses on individuals at risk. The genetic screening of workers is one such example. This is not undertaken for epidemiological reasons, but for picking individuals out to remove them from the workplace.

This set of tests is in a state of infancy, yet they are now being used to discriminate against individual workers. There is a need to notify workers who are subjected to these tests, although not epidemiological studies, and to prevent discrimination against them.

Do I have a few minutes more?

Senator METZENBAUM. Really not; you have gone over your time, and we have a number of witnesses.

Dr. ASHFORD. All right.

Senator METZENBAUM. The chairman has some pressing commitments, and so do I, so we are trying to be able to hear all of our witnesses.

Dr. ASHFORD. Thank you.

[The prepared statement of Dr. Ashford follows:]

TESTIMONY ON S. 2050

"THE HIGH RISK OCCUPATIONAL DISEASE NOTIFICATION AND PREVENTION ACT OF 1986"

BEFORE THE SENATE SUBCOMMITTEE ON LABOR,
COMMITTEE ON LABOR AND HUMAN RESOURCES

MAY 15, 1986
WASHINGTON, D.C.

STATEMENT OF

NICHOLAS A ASHFORD, Ph.D., J.D.

ON BEHALF OF

THE AMERICAN PUBLIC HEALTH ASSOCIATION
1015 15th STREET, N.W.
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The Need for New Initiatives

Exposure of workers to toxic substances and harmful physical agents continues to be a serious primary cause of disease and injury in those workers and exacerbates disease and injury initiated by non-occupational factors. Research into the underlying mechanisms of occupational disease causation, epidemiologic studies of worker populations, and the appropriate use of human monitoring techniques such as medical surveillance and biological monitoring needs to be strengthened to meet the goals of an effective disease prevention effort on the part of federal and local government, as well as industry.

Fairness dictates that, in addition to being informed through federal and local right-to-know laws about the identity of toxic substances to which workers are exposed, workers also be informed about their health status. This includes both individually relevant information and information relevant to their membership in a class or population of workers at risk. This information is crucial if workers are to be able to take timely remedial medical action to protect their health, to exercise self-help actions to decrease harmful exposures, for example, through their legal right to refuse hazardous work[1], or to counter and discourage discriminatory actions on the part of employers and health care providers or insurers.

Neither the OSHAct, nor the regulations issued under the Act, such as the Hazard Communication Standard and the Medical Access Rule, provides adequate information to or adequate avenues for relief for the worker. Only a few standards issued under Section 6(b)(5) of the Act provide for adequate medical surveillance, and for none of the chemicals regulated through the approximately 450 Threshold Limit Values (TLU's) is medical surveillance required. The OSHA Hazard Communication Standard requires transmission of chemical identity, not measures of health status. The OSHA Medical Access Rule requires that employers provide employees access to health information; it does not require employers or the government to transmit vital health information to workers unless they request it. In order to request information, workers must know that it exists. That is why the proposed legislation is crucial.

There is also a need to build up a cadre of professionals to monitor, treat and counsel workers at risk and to create or improve institutional facilities and capabilities for occupational disease prevention and treatment.

Finally, the issue of possible discrimination of workers exposed to harmful work environments or suffering from occupational disease and injury is a very real one. It is essential that better institutional and legal protections be afforded workers if they are not to fall victim to programs ostensibly fashioned to protect their health.

Discussion of S. 2050

S. 2050 focuses on four important activities intended to advance occupational health: (1) to characterize worker populations at risk, (2) to establish a federal program for notifying and counseling those workers, (3) to improve the outreach and effectiveness of occupational and environmental health facilities, and (4) to protect workers from discriminatory action. The proposed legislation is a good start, but additional considerations may be advisable to effectuate better the general intent of the bill.

In thoughtful work, which I commend to your attention, Paul Schulte et al.[2,3] have noted the important distinction between workers who are members of a population of workers at high or increased risk of disease, and workers who are individually at high or increased risk. The distinction is important. Medical examinations may reveal individual workers with occupational disease who do not constitute a large enough number (prevalence) to draw a statistically significant conclusion that the population of workers are at risk. Yet there is no doubt, on an individual basis, that the workers are diseased. In contrast, genetic monitoring of worker populations may reveal a statistically significant number of workers with chromosomal damage, but because that damage can be caused by non-occupational factors and because the extent of damage may be person-specific, it is not yet scientifically determinable what an individual's risk really is, although the conclusion that the population of workers is at higher risk is warranted.

The proposed legislation does not adequately address the issue of individual risk. Yet, there is great activity in clinical and laboratory techniques for human monitoring which focus on detection of individuals at risk. The development of tests for human monitoring are in a state of infancy.[4] Yet, they may be used to discriminate against individual workers.[4,5] There is a need to notify the workers who are subjected to these tests, though not epidemiologic studies, and to prevent discrimination

against them, as well as to address the needs of the subjects of epidemiologic investigation. The proposed legislation does not adequately address this problem.

If we are to protect the subjects of epidemiologic studies, and I believe we should, we also must recognize that we need to strengthen the federal government's hand in conducting these studies in worker populations. According to current interpretations of law, under the OSHAct OSHA may be required to secure a court warrant before entering a workplace for inspection purposes. Though not tested, NIOSH may presumably be under the same requirement. In conducting epidemiologic studies, NIOSH has skirted the issue by agreeing in a number of court-supervised compromises to keep confidential the names of individual workers who are studied.[6] Further, in practice, NIOSH has not always informed individual workers of the results. Because employer resistance would probably increase, and because employer cooperation would be difficult to obtain, NIOSH has been placed in a difficult ethical position. The proposed legislation requires the Secretary of H.H.S. to notify workers. It should also clearly express the intent of Congress that health agencies are to be given free entry to industrial workplaces without the necessity of obtaining a warrant or giving a tacit or implicit promise not to notify the workers about the results. Otherwise, employers are unlikely to cooperate with a NIOSH, CDC, or Center for Disease Statistics investigation.

Making decisions on how and when to notify workers presents difficult legal and ethical questions.[2,4,5] For this reason, it is crucial that legislation provide procedural and institutional safeguards of fairness. Medical monitoring can serve not only to detect individuals and populations at high or increased risk, it can also provide intervention strategies that prevent, reverse, arrest or merely treat occupational disease and injury. Legal and ethical concerns are different for different cases.

The guidance given to and the role of the Risk Assessment Board must be carefully considered. The legislation should require a minimum number of meetings, provide an adequate operating budget and provide for congressional oversight.

In making a determination of "populations at risk," as defined in Section 3(6), it is crucial to recognize that the populations to which working groups should be compared must take into account the "healthy worker effect" which

recognizes that unexposed workers are in fact healthier than the general population, and therefore a modest increase of morbidity or mortality above the general population may indicate a serious health situation for those workers.[7,8]

Section 4(b)(4) should be expanded to clarify the point that conclusions of risk status for notification purposes are in the nature of science policy determinations and do not need to be supported by the same degree of scientific rigor or proof needed to support other purposes of drawing causal inference.

Section 5(a)(3) should be added to the legislation requiring that the Secretary not be able to depart from the recommendations of the Board without publishing the reasons for departure in the Federal Register. With these requirements, public servants will be held accountable in a way which checks abuse and ensures decisions in the sunshine. This "act or explain" requirement imposed on the Secretary parallels similar requirements placed on the Administrator of EPA in implementing the Toxic Substances Control Act. It seems to be a prudent citizen safeguard.

The judicial review provided in Section 5(i) should be expanded in two ways. Employees or their representatives, as well as others, should be given the opportunity to obtain review. In addition, review of the Secretary's decision not to notify workers should likewise be subject to review. Otherwise inaction on the part of the government will go unchecked.

In addition to top priority being accorded substances for which standards have been set under Section 6(b)(5) of the OSHAct, special attention should be paid to the approximately 450 TLV's adopted under Section 6(a), to which OSHA's Standards Completion Project appended only voluntary guidelines for medical monitoring. It may be more important to uncover disease from exposure to the substances inadequately regulated under a TLV, than to track the 6(b)(5) substances. In addition, substances classified, though not yet regulated, as carcinogens under the OSHA Generic Carcinogen Standard should receive serious legislative direction for review by the Board.

Access of the Risk Assessment Board to employer or manufacturer information reported to EPA under Section 8 of TSCA is essential. Both epidemiologic studies and individual worker adverse health reactions are

required to be reported.[9] Workers need to be notified of the results. Although arguably reachable through the OSHA Medical Access Regulation on request, Congress should provide an affirmative notification requirement on the Secretary in Section 5(e) of the proposed legislation so that both individuals and populations at risk are adequately notified.

On the issue of discrimination, Section 8 should require hearings at the regional level--unlike OSHA's discrimination hearings--so that complaints can be easily filed and adjudicated. Conclusions by the Secretary that workers are at high risk should be explicitly admissible in OSHA and NLRB proceedings to adjudicate workers' right to refuse hazardous work or discrimination complaints filed under OSHA and other federal laws. It is also crucial to clarify Congress' intent that notification of workers does not lessen the obligations of employers or manufacturers to provide safe and healthful workplaces and products, and that such notification does not create a presumption of informed consent to future exposure.

I wish to congratulate the Committee on a good start in meeting its important public health goals. I hope these constructive criticisms will help strengthen the legislative initiative.

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Note: References 1, 4, 5, 7, 8 and 9 are submitted for the record.

Editor's Note: In the interest of economy, the above-mentioned references were retained in the files of the Committee.

Senator NICKLES. I will just make a quick comment. One, I wish to apologize to our previous panel and to this panel for missing your statements. It was necessary for me to testify before the House, and that is the reason why I had to leave at 10:20.

I have glanced at your statements and will review them in more detail, and I appreciate your appearance before the committee.

As Senator Metzenbaum said, we are both trying to get out of here in short order, and we have five more witnesses, and in all deference to them, we want them to have a fair shot before the committee as well.

Senator METZENBAUM. I am just going to ask you to answer these with a "yes" or "no." Dr. Selikoff, in your experience, can a notification program promote early medical intervention to prevent or successfully treat occupationally related disease?

Dr. SELIKOFF. It can help, surely.

Senator METZENBAUM. Do you have any question about that, Dr. Finklea?

Dr. FINKLEA. No.

Senator METZENBAUM. And Dr. Ashford, do you agree, also?

Dr. ASHFORD. Yes, I agree.

Senator METZENBAUM. And then let me ask you, can notification serve as a catalyst to change workers' personal health habits?

Dr. FINKLEA. I am not sure. I hope it can. I will give you the best example I can on that, and that is that the personal notification about risk of coke oven exposures, in my experience, did a great deal as far as getting workers to control their hypertension. It did not change too many people's minds on smoking, I am afraid.

Senator METZENBAUM. Dr. Ashford.

Dr. ASHFORD. I believe that notification can sensitize workers to exercising legal, political, and regulatory mechanisms which they need to exercise. One of the reasons I think that the notification is being resisted is because it is likely to stir up a great deal of local activity, and I believe that notification is essential for that reason. There are many ways to improve your health status.

Senator METZENBAUM. Thank you.

Dr. Selikoff.

Dr. SELIKOFF. The answer is yes, sir. For example, once asbestos-exposed workers understood, they changed their lifestyle. They no longer take their work clothes home for their wives to wash, and 20 and 30 years from now, we are going to see fewer mesotheliomas among wives and children of asbestos workers.

Senator METZENBAUM. Thank you very much. I want to thank the panel members, and I think I as well as some other members of the committee may have some questions to submit; obviously, the chairman has already indicated he does.

Senator NICKLES. Thank you all very much.

Our next panelists are Dr. William Gaffey, director of epidemiology at the Monsanto Co., representing the National Association of Manufacturers, and Dr. Clarence Kluck, medical director, Cyprus Coal, on behalf of the American Mining Congress.

Dr. Gaffey, please proceed.

STATEMENT OF DR. WILLIAM R. GAFFEY, DIRECTOR OF EPIDEMIOLOGY, MONSANTO CO., ST. LOUIS, MO, ON BEHALF OF NATIONAL ASSOCIATION OF MANUFACTURERS; AND DR. CLARENCE KLUCK, MEDICAL DIRECTOR, CYPRUS MINERALS, ENGLEWOOD, CO, AND BERNARD R. ROY, CORPORATE DIRECTOR OF LOSS PREVENTION, AMAX INC. AND CHAIRMAN, AMERICAN MINING CONGRESS, ACCOMPANIED BY HENRY CHEYETTE, SENIOR COUNSEL, AMERICAN MINING CONGRESS

Dr. GAFFEY. My name is William Gaffey. I am epidemiology director for the Monsanto Co. My curriculum vitae is, I believe, in your hands already. I would like to add only one sentence, which is that I was the coauthor of the first published study that documented and quantified the relationship between vinyl chloride and liver cancer.

I have written testimony, which I hope will go into the record, and what I would like to do now is to summarize very briefly my concerns and those of the NAM for the proposed legislation.

To begin with, no one can deny the obligation of society to prevent or, failing that, to lessen the health consequences of occupational exposure. My concern with the proposed bill is that first of all, I believe it to be redundant. There is regulation to this effect being promulgated by OSHA. We do not at this time have any evaluation of that regulation. If that regulation turns out to be ineffective, it may indeed be appropriate to have some such law as the one that is proposed. But at the moment it is redundant, but also, I see several problems with it as it now stands.

First of all, the bill proposes to use data from laboratory and clinical observations as well as epidemiology studies to characterize populations that are at excess risk. It seems to me that laboratory and clinical data are inappropriate for this purpose. The purpose of laboratory and clinical data is to ask questions, not to answer them. Much of the laboratory work that is done is done on substances for which there is no human exposure. Much of the rest is done at the behest of organizations like EPA in order to extrapolate and to estimate low-dose exposures in human populations. I know of no way in which these data can be used to characterize high-risk populations as defined in the bill. On the other hand, epidemiology studies of human beings can do so.

My second point is that the criterion used in the bill is not a reasonable one, the criterion of a 30-percent excess mortality. My reasons are fairly straightforward. A rare cause of death, if it has a 30-percent increase, does not affect very many people. A very common cause of death with a smaller increase might affect many more people. Perhaps the clearest example comes from nationwide data on mortality. If we look at leukemia, which is a rare cause of death, and cardiovascular disease, which is a common cause of death, a 30-percent increase in leukemia would result in several hundred additional deaths per year; a 10-percent increase in cardiovascular disease would result in tens of thousands of deaths per year.

By the criterion of the bill, we would be paying great attention to the hundreds of cases of leukemia and ignoring the tens of thousands of cases of cardiovascular disease. This becomes more of a

problem because the likelihood for rare causes of seeing an excess by chance alone is greater.

This brings me to my third point, which is that the criterion as embodied in the bill ignores statistical variation. Now, in the typical occupational epidemiology study, there will be several causes of death in which the number of observations will be small, and the expected values will be less than one. It is not unusual to have several causes of death in such a study with expected values of something like 0.5.

Obviously, in such a case, if you have any excess at all, it has got to be 100 percent. In other words, for a rare cause, the probability is rather large that you would see a big excess by chance alone.

Now, one can do calculations in this area, but rather than doing that, I took a survey. I looked at the five leading epidemiology journals and asked someone on my staff to go back to December 1985, take all the issues that we had in hand from that time forward, and to look at all of the mortality studies within them; there were 23 of these. I asked her to identify which of these had found a 30 percent excess risk from some cause of death, and the answer was 23 out of 23. In other words, by the standard in the bill, every study published in the last 6 months of any occupational group anywhere has shown a group with at least a 30 percent excess risk from some cause of death, and therefore a group worthy of notification.

So if the law exists, or existed in this form, the increasing number of studies that are being done by industry would, to put it mildly, be discouraged, because doing a study would be equivalent to identifying a group that was at excess risk.

I think the final point is that even if one grants the validity of the 30-percent criterion, and if one does not worry about statistical variation, the act of notification bears a cost as well as a benefit.

One example, I think, is the study of which I was coauthor of vinyl chloride exposure, in which 10,000 people were studied. Now, the liver cancer caused by vinyl chloride is a rare one. There have been something like 100 deaths worldwide in the last 15 years, possibly half of those in the United States. Therefore, the 10,000 people that I studied would have been expected to generate perhaps 50 deaths from a cause of death, a condition which is always fatal, and which cannot be detected until it becomes symptomatic.

Now, if we, under this law, had been forced to notify these people, we would have been notifying something like 9,000 people, because 1,000 or so died in the course of the study; of that 9,000, 8,950 of them would never have gotten the condition in question. There was no way to predict which 50 would have gotten it. The 50 who got the condition would unfortunately have died; it would have been impossible to prevent that event.

Senator NICKLES. Dr. Gaffey, thank you very much for your comments.

We will come back to you in just a moment.

[The prepared statement of Dr. Gaffey and responses to questions submitted by Senator Metzenbaum follow:]

National Association of Manufacturers

TESTIMONY OF

WILLIAM R. GAFFEY, PH.D.
EPIDEMIOLOGY DIRECTOR, MONSANTO COMPANY

ON BEHALF OF THE

NATIONAL ASSOCIATION OF MANUFACTURERS

BEFORE THE

SUBCOMMITTEE ON LABOR
COMMITTEE ON LABOR AND HUMAN RESOURCES
UNITED STATES SENATE

ON

S. 2050, THE HIGH RISK OCCUPATIONAL DISEASE NOTIFICATION AND PREVENTION ACT OF 1986

MAY 15, 1986

1776 F Street, N.W. • Washington, D.C. 20006 • (202)637-3000

Good morning, Mr. Chairman and members of the subcommittee. My name is William R. Gaffey, Ph.D. I am Epidemiology Director for the Monsanto Company. Although the members of the subcommittee have received a copy of my curriculum vitae, I would like to add that I was the coauthor of the first published epidemiology study that documented the association between vinyl chloride and liver cancer. I am, as far as I know, the only industry epidemiologist who is an Associate Editor of the American Journal of Epidemiology. I am here today to present my concerns as an epidemiologist with S. 2050, "The High Risk Occupational Disease Notification and Prevention Act of 1986" on behalf of the National Association of Manufacturers (NAM).

The National Association of Manufacturers is a voluntary business association of over 13,500 corporations, large and small, located in every state. Members range in size from the very large to over 9,000 smaller manufacturing firms, each with an employee base of less than 500. The NAM member companies employ 85 percent of all workers in manufacturing and produce over 80 percent of the nation's manufactured goods. NAM is affiliated with an additional 158,000 businesses through its Association Council and the National Industrial Council.

Introduction

The National Association of Manufacturers, and I personally, support the concept behind S. 2050, that workers should be informed of the risks of contracting occupational diseases as a result of their employment, particularly when early medical intervention can reduce that risk or at least ameliorate the effects of such diseases. NAM believes that S. 2050, however, will not achieve that goal and will have adverse effects that outweigh any of its beneficial results.

The bill is so broad that it would basically require every company to notify every employee of every potential disease, whether or not the risk was great. It creates an entirely new structure to do what a number of government agencies already require. This type of approach will undoubtedly cost industry billions of dollars, and in the final analysis, the goal of notifying employees of serious risks won't be achieved. There are many specific fundamental problems with S. 2050. First, the use of clinical, laboratory and animal data is prescribed by the bill and is not relevant because such data cannot be used to estimate high risk as defined in this bill. Second, characterizing the existence of an excess risk by a percentage figure will direct resources toward conditions of lesser importance and will overlook major hazards. Third, the definitions of excess risk used in the bill ignores statistical variation, so that resources may be used to deal with problems that do not in fact exist.

Fourth, the process of notifying persons who may be at increased risk has a monetary cost, and a social cost in terms of trauma to those who will in fact never become ill, costs which are not taken into account in the bill. Fifth, manufacturers are extremely disgruntled that Congress is contemplating establishing a program of this type when the second phase of OSHA's Hazard Communication Standard, which will provide notification to employees about occupational hazards and their associated risk of disease, has not even gone into effect yet. This shows an absolute lack of confidence by the Congress in the effectiveness of its own existing programs, as well as a disregard for manufacturers' strenuous efforts to comply with the substantial disclosure requirements of the Standard. NAM believes we should wait and see how effective the OSHA program is before we launch into another program that will be redundant and unnecessary. Sixth, the measure will be very burdensome and intrusive.

I would now like to elaborate on each of these concerns:

1. <u>The Use of Clinical, Laboratory and Animal Data</u>.

Clinical data, that is, the use of case reports of persons who are ill, are frequently useful in identifying potential problems that are worthy of careful investigation. In other words, clinical studies provide questions, not answers. Conclusions based on clinical observations can be tragically wrong, as was the case with the drug DES. Clinical observations led doctors to

believe that the drug was effective in preventing miscarriages. It was subsequently widely used, and has been associated with vaginal cancer in the daughters of mothers who used the drug during pregnancy. The tragedy is only partly that DES caused vaginal cancer. The equally tragic fact is that it is not useful for its intended purpose, and would never have been used if the original clinical observations had been followed by a careful scientific trial.

Laboratory and animal data have an essential place in estimating the effects of substances that are contemplated for use. Although the interpretation of such data is subject to great controversy, there is general agreement that we cannot as a society release substances into the occupational or general environment if laboratory or animal data suggest that they are likely to be harmful. However, these data, by definition, deal with substances to which there is no human exposure.

Other laboratory and animal data have been used to estimate virtually safe doses for substances that are currently in use. The data are used because the concern is with extremely low exposures and estimated effects which are too small to be observable in human populations. I know of no way in which such studies can be used to estimate high risk as defined in this bill. Study of exposed human populations can do so.

As examples of the difficulties in establishing substantial human risk from animal studies, I offer the cases of arsenic and vitamin C. Arsenic is a known human carcinogen which does not cause cancer in animal studies. Vitamin C is an essential human nutrient, the lack of which causes illness and death. Rats produce their own vitamin C, so that dietary studies of rats could never establish the harmful effects of deprivation of vitamin C.

2. The Fallacy of Using Percent Excess as a Definition of High Risk.

If a condition is normally rare, a large percentage increase in the incidence of the condition will cause relatively little illness or death. On the other hand, a small percentage increase in a common condition can cause a great deal of illness or death. For example, consider cardiovascular disease and leukemia in the United States. A 10 percent increase in the risk of death from cardiovascular disease would produce tens of thousands of excess deaths, while a 30 percent increase in the risk of death from leukemia would produce a few hundred excess deaths. By the criteria of the present bill, resources would be spent to reduce the few hundred leukemia deaths, but the tens of thousands of cardiovascular deaths would be ignored. The criteria in effect requires the Risk Assessment Board to ignore major sources of disability and death if they constitute small percentage increases in illness or death.

3. The Bill Ignores Statistical Variation.

The risk that is observed in studies of human populations is based on a comparison between the number of cases or deaths from a given cause that is observed compared with what would be expected if the population were unexposed. The observed number is therefore subject to chance variation which can be extremely large if the expected number is small. For example, in follow-up mortality studies of employed populations it is not uncommon to have several rare causes of death for which the expected number of deaths is as small as one-half. In such cases, one can only observe either a gross deficit (i.e. no observed deaths) or an excess of 100 percent or more (i.e. one or more observed deaths). In addition, such studies typically investigate some 30 or more causes of death, so that the likelihood that there will be at least one large excess by chance alone is large.

Rather than calculating the theoretical probabilities of such things happening, I have surveyed the recent literature of published epidemiology studies to see how many of them showed a high risk as defined in the bill. I looked at all available issues of five leading journals since December, 1985 and found 24 studies of mortality in occupationally exposed populations. In all 24 of them, there was at least one cause of death that showed an excess risk of 30 percent or more among people with a

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specified occupational exposure. This means that, by the criterion of the bill, every recent study of occupational mortality has shown that the population studied was at high risk. Furthermore, in most such cases the authors of the study, taking into account statistical variation, concluded that there was in fact no real excess risk. In most of the remaining cases the authors concluded that there was only an indication or a suspicion of risk which would have to be confirmed by other studies of similar populations.

The Risk Assessment Board would most likely use the same reasoning as the authors of these studies. This means that the Board would be forced by scientific logic to make decisions that contradicted the criterion of the bill. Perhaps the least serious result would be that the Board, or the Secretary of Health and Human Services, would be subject to lawsuits because of their failure to follow an illogical criterion as prescribed by law. At worst, the Secretary might overrule the Board because of its failure to follow the law, with the result that practically every epidemiology study would be the basis for notification of the members of the study population. Since doing a study would always mean finding an excess risk, industry groups and companies that now study their employees would be, to put it mildly, discouraged from doing so.

4. The Costs of Notification May Exceed The Benefits.

If all the above difficulties were resolved, the question would still remain whether the benefits of notifying workers, most of whom would never become ill, that they were "at risk" would exceed the social and monetary costs involved.

The cost of locating, notifying and counselling each affected worker as contemplated by the bill would be enormous. The estabishment of at least one health center per state throughout the United States borders on creating a national health care program and would have staggering and incalculable costs.

Under S. 2050, the cost of testing, evaluating, and medically monitoring "at risk" workers would be assumed by an employer on the same basis as any other health care item. This coverage would be a mandated benefit, and health insurers could subrogate claims against a workers' compensation program or other insurance carrier. This measure would, therefore, greatly increase the cost of employers' health insurance and workers' compensation insurance, compelling many employers to drop their coverage altogether. It would lead to an availability and affordability crisis in these types of insurance.

Litigation costs for employers would also skyrocket under the scenario proposed by S. 2050. As a result of notification of the potential for injury, employers will be confronted with many

lawsuits alleging harm and fear of future harm.

At the same time, it is very likely that the vast majority of workers who are notified that they are "at risk" will never become ill. Let me give you an example. A study sponsored by the Chemical Manufacturers Assoiation of about 10,000 vinyl chloride workers established a greatly increased risk of angiosarcoma, a rare liver cancer, in such workers. The estimated number of deaths from that cause in workers exposed to vinyl chloride is about 100 worldwide, of which perhaps half occurred in the United States. Assuming that all these deaths occurred among the 10,000 workers referred to above, if the present bill had been the law at the time of the study, it would have been necessary to find, examine and counsel about 9,000 workers (the rest had died from all causes by the end of the study period), 99.5 percent of whom would not have gotten the cancer in question. All of them, however, would have been treated, by themselves and by society, as people who were apt to die of angiosarcoma. Since there is no cure for the condition, nor any way to predict it, an immense amount of money would have been spent to fail to identify people who, had they been found, could not have been helped. The cost, in addition, would have included the concern and worry created in the 99.5 percent of the group who in fact would never get the cancer.

I do not know at what point the cost in personal disruption to an exposed group outweighs the benefit from notification and

counselling, but I do know that such a point exists. Where that point is reached is a societal decision which is not addressed in the present bill.

5. The Measure is Redundant and Unnecessary.

NAM believes that the Hazard Communication Standard as promulgated by OSHA will sufficiently provide for notification to employees of hazards in the workplace and their potential health effects. This standard, which goes into effect in ten days, imposes several affirmative obligations on employers. One such obligation is that employers must inform their employees through training programs, material safety data sheets, and labelling, of the physical and health dangers associated with the hazardous materials in their work areas. Once in force, this Standard will provide the mechanism for employees to obtain knowledge, awareness and appreciation of the hazards in their places of employment. NAM believes we should wait and see how effective this new program is before the government creates an entirely new, burdensome, and costly program under S. 2050.

Further, S. 2050 would create an overlapping and expensive bureaucracy with other federal agencies already charged with protecting workers' health at a time when severe budget cuts are pending. Several federal agencies, including The Occupational Safety and Health Administration, The National Institute for Occupational Safety and Health, The Mine Safety and Health

Administration and The Environmental Protection Agency, are already responsible for regulating hazardous exposures both in and out of the workplace. The bill would create programs which duplicate the authority which OSHA and NIOSH already possess under the Occupational Safety and Health Act. For example, NIOSH already is tasked with performing occupational health research and serving as a clearinghouse of information, and both NIOSH and OSHA have authority to disseminate information regarding risks from occupational exposure to toxic and hazardous substances. In addition, the program which S. 2050 would create would be administered by the Department of Health and Human Services instead of the Department of Labor. At a time when the federal forum is already crowded with agencies to protect workers' health, NAM questions the need to involve another Department in this area.

6. The Bill is Intrusive and Burdensome to Comply With.

The bill sets forth a complicated individual notification program which proposes free access by the Secretary to the records of any federal agency to obtain names, addresses and work histories of employees subject to notification. The Secretary also has access to data contained in employers' records insofar as Federal access is already provided for under the Occupational Safety and Health Act of 1977. It further provides that the Secretary can certify a private employer or state or local govenment to conduct this notification. This could result in various government agencies

or private employers having access to other private employers' Internal Revenue Service and social security records. This could easily amount to an invasion of employers' privacy and could lead to all types of abuses. An employer should not be compelled to disclose this information to all of these parties. Regulations promulgated pursuant to this aspect of the legislation could be onerous and burdensome.

Conclusion

The NAM agree with the concept behind S. 2050 that workers should be informed of the risks of contracting occupational diseases as a result of their employment. However, the decision as to whether an occuptionally exposed population is really at higher risk than the general population with respect to certain diseases is a complicated one. The recipe for the decision cannot easily be written explicitly into law. The further decision as to whether the excess risk, if it exists, warrants notification, is a function of the degree of excess, the percent of the exposed population that is potentially affected, and the benefits of notification versus the costs of unduly alarming thousands of people.

In addition, OSHA currently has devised a system through its Hazard Communication Standard which informs workers of health hazards which is complex and comprehensive, not to mention costly.

For all of the above reasons, NAM believes that S. 2050 is an ill-considered measure that would not achieve its stated goal.

National Association
of Manufacturers

June 13, 1986

Ms. Charlene Abshire
Senate Labor Subcommittee
Committee on Labor and
Human Resources
428 Dirksen Senate Office Building
Washington, D.C. 20510

Dear Charlene:

Senator Nickles forwarded three questions to the NAM at Senator Metzenbaum's request. These questions relate to NAM's appearance before the Labor Subcommittee on May 15 to testify against S. 2050, the "High Risk Occupational Disease Notification and Prevention Act of 1986." This letter will answer the three questions.

1. Should employers give federal health agencies free access to industrial workplaces in order to gather risk data?

   No. Access should be limited by time-tested Fourth Amendment principles. Before access is given to a federal health agency, the purpose, rationale, obligations, and consequences of the visit should be clear to both the employer and the agency. These safeguards can then prevent the government from going into an employer's premises on a fishing expedition, without inhibiting legitimate, scientifically sound investigations.

2. If this bill became law, would your members be more likely to refuse entry to federal health agencies, e.g., to NIOSH doing a retrospective cohort mortality study?

   There would probably be resistance to allowing an agency such as NIOSH to have access to employer records for the purpose of doing a retrospective cohort mortality study. Under the 30 percent test in S. 2050, such a study would almost certainly conclude that the study population was at risk, no matter what the true situation. Since the government agency's entry into the employer's premises in order to do a study would basically be equivalent to labelling the employer's workers as a population at risk, employers would be very likely to refuse entry to federal health agencies.

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In addition, employers are concerned that as a consequence of these studies determining that an employee population is at risk, a great deal of litigation will develop, much of it without real merit, because of the bill's faulty 30 percent test. The notification that employees are at risk is almost certain to result in substantial litigation by workers against manufacturers of the substance studied. Much of the litigation will involve workers who sue over fear of contracting the disease, or workers who sue over the increased chance of contracting the disease. Consequently, this legislation could increase the current tort liability crisis. While the manufacturers may prevail in the litigation that will ensue, the high cost of defending these cases will have to be paid by them. This is another reason why if this bill becomes law, manufacturers would be more likely to refuse entry to federal health agencies who conduct studies.

3. You mention the emotional distress of workers who are inappropriately notified. A study by Hornsby and others concerning the psychological impact of notification on a group of workers at risk of bladder cancer, which appears in the April 1985 Journal of the American Medical Association, found no evidence of psychological trauma from mere notification of risk. Are you aware of any studies that reach a different conclusion?

No. However, several points should be made regarding the Hornsby study. First, in the same issue of the Journal of the American Medical Association, there is an editorial by M. J. Horowitz, inventor of one of the psychological scales used by Hornsby et al., that refers to a large study by Horowitz and others of the stressful impact of notification of increased risk of heart disease from high blood pressure, high cholesterol, or cigarette usage.

Secondly, the Hornsby study is so poor that the results cannot be accepted with any confidence. The sample that was screened was a set of volunteers from a larger group who were themselves volunteers, and the authors either do not know or have chosen not to state the numbers involved at each stage. Accordingly, we cannot determine how selective their sample actually was. In

fact, they do not seem to know the size of their own sample. They state that they screened approximately 170 people who responded from a random sample of unknown size. The sample was taken from a group of unknown size who were given physical examinations. These in turn were the respondents to an unknown number of notifications that were sent out. Finally, the authors state in the test that 128 of their sample were rescreened six months later, but one of their tables shows test-retest data for 115 people and the other shows test-retest data for 104 people. The authors apparently do not consider the discrepancy important enough to mention in the text.

Thirdly, Horowitz states in her editorial that about 17 percent of over 1000 people in her study were at or above a moderately stressed level from the news of high risk, as measured by one of the psychological tests used by Hornsby, et al. (A comparable figure was not given by Hornsby, et al., although it could have been calculated by them.)

In most people's view, being told that they are at increased risk of cancer is much more traumatic than being told they are at increased risk of heart disease, so it is reasonable to estimate that at least 17 percent of the bladder cancer group were in fact upset. If they were so upset as not to come in for an examination, or so upset as not to agree to be screened, or so upset as not to come back for a second screening, they would never appear in the Hornsby paper.

We hope our answers are helpful to you.

Sincerely,

Elizabeth A. Ramsey

Elizabeth A. Ramsey
Associate Director
Loss Prevention and Control

EAR:djf

Senator NICKLES. Mr. Roy.

Mr. ROY. Mr. Chairman and committee members, my name is Bernie Roy, and I am the director of loss prevention for AMAX, Inc., in Greenwich, CT, and I also serve as the chairman of the AMC Health Committee. On my right is Dr. Clarence Kluck, with Cyprus Minerals, and he will address the medical issues. On my left, Mr. Henry Chajet, senior counsel for the American Mining Congress.

All the points that we wanted to make today have been raised and discussed by some people in one form or another, so I will try to be brief, bearing in mind that the statements will be attached to the record. So we will try to make the key points that we want to make.

Senator NICKLES. Thank you.

Mr. ROY. The American Mining Congress is a trade association representing most of the mining companies that mine coal, metals, manufacturers of mining and processing equipment, as well as mining supplies.

The people that we represent are under the jurisdiction of the Mine Safety and Health Administration, primarily MSHA, and I would like to address just a few key issues here on MSHA that were not raised before. We agree with the hazard communication rule; we agree with the problems associated with the definition of risks, and we have also heard some testimony on the costs of the bill, and these are addressed in our prepared text.

The point that I want to make with MSHA is that we are regulated by them to offer training to our workers, to give training to our workers. Our underground workers must undergo 40 hours of mandatory training before they go underground, before they do their job. Those on the surface are also mandated to get 24 hours of training and all miners—surface and underground—receive 8 hours of refresher training. A majority of that training includes training in site-specific hazards, and therefore our people do have the benefit of the notification as well as the identification of problems.

Now, in addition to that, OSHA notwithstanding, we also have several independent Government agencies or independent studies that are conducted at our mines. NIOSH, I think, earlier mentioned the fact that they have hazard evaluation surveys of OSHA-dominated, or OSHA-regulated, as well as MSHA-regulated facilities, and we get the results of those. In addition to that, MSHA also conducts in cooperation with OSHA and particularly NIOSH, special research projects. And you may well be aware that we have been continuously studied on diesel emissions, on heat stress, silica, coal dust, respirable coal dust, and on and on. So in other words, they are studying the problems that are associated with our mining operations.

The results of the NIOSH studies and all MSHA enforcement efforts and regulatory requirements are communicated equally to the employer and employee representatives. I may point out that the employees and their representatives are given and routinely exercise the right to be involved in both these enforcement, inspection, investigation, and research projects.

Now, in addition to all of these communication efforts, we should also be aware that both OSHA and MSHA have safe operating limits. In other words, they have permissible exposure limits for these various substances that one must abide by, and if we do not meet these, there is stringent enforcement activity. As a matter of fact, on health issues, we are given significant and substantial violations which can run the gamut from penalties all the way to closure of that particular operation. So they have a significant enforcement responsibility.

With respect to the potential costs, we are conducting a study to actively predict the direct costs of this bill, and we hope to forward it to you for inclusion in the record.

One point I would like to raise and bring to your attention is that we feel that the $25 million budget is quite low. And I think our experience with the black lung compensation will bear that in mind. Until the recent reforms were enacted, the GAO found that more than 87 percent of all black lung claims were granted without adequate medical basis. Thus the cost of the Federal program, not counting employer-paid claims, is almost $700 million per year. This contrasts to an estimate of $32.3 million per year touted by the program supporters back in 1969.

Well, without further ado, let me pass it on to Dr. Kluck, who will talk about the notification and intervention scheme of S. 2050.

[The prepared statement of Mr. Roy follows:]

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Testimony On

S. 2050,

"The High-Risk Occupational Disease Notification and Prevention Act of 1986"

May 15, 1986

Good morning, my name is Bernard Roy, and I am the corporate director of loss prevention for AMAX Inc., and chairman of the American Mining Congress (AMC) Occupational Health Committee. Also testifying with me on behalf of AMC is Dr. Clarence Kluck, corporate medical director for Cyprus Minerals Company, Englewood, Colorado.

Mr. Chairman and members of the Committee, we appreciate this opportunity to appear before you and provide you with our views regarding S. 2050, the "High-Risk Occupational Disease Notification and Prevention Act of 1986."

As you know, AMC is a national trade association representing the vast majority of the producers of the nation's metals, coal, industrial and agricultural minerals, and the manufacturers of mining and mineral processing machinery, equipment and supplies.

AMC testimony is the result of a careful analysis by the health and safety experts of our many member companies. Their comments and views are reviewed and formulated into an industry-wide position by AMC's Board of Directors' standing Committees on Health, Safety and Industrial Relations.

As spokesman for the industry, AMC can relay to you our commitment to protecting the safety and health of the miners who produce our nation's minerals. While we certainly share the goal of fostering the health and safety of our employees, we have significant objections to the provisions of S. 2050.

Our concerns with S. 2050 can be categorized under three major headings. First, we do not believe that S. 2050 is needed

to accomplish worker notification, nor our common goal of employee protection. Second, the details of S. 2050 are extremely disturbing due to their vagueness, and in some cases inappropriateness. Third, the costs of conducting the program envisioned by S. 2050 could be staggering, financially to the government and industry, and emotionally to the employees involved.

Initially, we seriously question the need for S. 2050. The statutes creating the Occupational Safety and Health Administration (OSHA) and the Mine Safety and Health Administration (MSHA) require the Secretary of Health and Human Services, through his research arm, the National Institute for Occupational Safety and Health (NIOSH), to conduct research and evaluations. The regulations of these agencies require a variety of health protections, training and communication of hazards to the employees.

Workers are regularly trained regarding the hazards of workplace exposure to potentially toxic substances. As you know,

MSHA requires a minimum of 40 hours initial training for underground employees and 24 hours initial training for surface employees. Initial training covers the hazards that an employee may be exposed to and is supplemented on an annual basis by a minimum of at least 8 hours of refresher training. The mandated training program is oriented to site-specific hazards and includes toxic substance hazard and protection training.

Under the OSHA hazard communication regulations, employees must be provided with information regarding hazards and the safe handling of potentially toxic materials. Inherent in this training is site-specific education of employees on the potential health effects of their exposures. Similar requirements have been enacted by many state and local governments.

Independent of any government requirements, AMC's member companies have found it in their best interest to identify potential hazards, and control or eliminate potential employee exposures to these hazards. The large variety of mining and

processing operations represented by AMC, and their inherent differences, prohibit an in-depth description of the protective measures that our member companies undertake. However, we can assure you that all of our member companies are committed to the statement in our Declaration of Policy that ". . . pledges [AMC's] continued cooperation in achieving the common goal of all parties involved in safety and health: the protection of the workforce" (copy attached as Appendix 1).

In addition to regulatory and company initiatives aimed at identifying and protecting against potential toxic hazards, extensive preventive measures result from independent government activities. For example, both MSHA and OSHA conduct extensive industrial hygiene inspections at workplaces. These inspections entail an evaluation of hazards and enforcement action if employees are not being protected. As you know, MSHA is mandated to inspect each underground mine at least four times per year and each surface mine twice per year. MSHA and OSHA inspection activities are supplemented by NIOSH, which conducts routine

health hazard evaluations and a large number of specialized research projects aimed at analyzing employment hazards.

The mining industry is currently undergoing an extensive evaluation of potential health risks through NIOSH's National Occupational Health Survey of Mining. A similar extensive study has already been completed for general industry. This NIOSH mining project alone will provide an in-depth analysis of potential hazards throughout our industry through a randomized site visitation program of approximately 900 mines representing all mining commodities over a 5-year period. AMC is cooperating with NIOSH on this project and has retained an experienced certified industrial hygienist to monitor the project and provide seminars for affected mine operators. This effort will assist in making NIOSH visits a positive experience for mine health programs. The NIOSH survey will provide an industry-wide inventory of potentially toxic material and an extensive library of "material safety data sheets" for use by government and industry. Similar

libraries and resources are being developed independently by MSHA and OSHA.

These general programs are supplemented by either site-specific health hazard evaluations or substance-specific research projects. In 1984 and 1985, NIOSH conducted numerous health hazard evaluations at a large number of industrial sites. Concurrently, the Institute conducted research on many potentially toxic substances and processes. For example, in mining alone, NIOSH studied the effects of diesel emissions, heat stress, silica exposures, coal dust, radon daughters, welding fumes, asbestos, and hand and arm vibration.

The results of these NIOSH studies are communicated to both employer and employee representatives. Similarly, all MSHA and OSHA enforcement efforts and regulatory requirements are communicated equally to employer and employee representatives. Most importantly, employer training programs include hazard analysis, communication, and protective techniques. These training programs incorporate many of the findings of the government's

research activities and are, of course, provided to the employees directly.

Although we cannot speak for the federal agencies involved, we can relate to you our experience that they have never hesitated to provide pertinent information to employee representatives and, where appropriate, to the employees themselves.

In response to 1985 charges by the Public Citizen Health Research Group that NIOSH had suppressed evidence of occupational disease among American workers, HHS Assistant Secretary for Health, Edward N. Brandt, Jr., detailed the procedures by which NIOSH notifies workers of the results of health hazard evaluations. Dr. Brandt also noted that workers are always advised of the results of NIOSH-conducted medical tests.

Results of epidemiological studies that involve review of records, but seldom involve direct contact with the individual worker, are released to the employer, the employee representative, the Department of Labor and appropriate state agencies.

Dr. Brandt reported that NIOSH is reviewing the advisability and possible procedures for informing individual workers of the results of these retrospective epidemiological studies. He noted, however, that a final decision involves "complex moral, ethical, medical and legal issues."

Copies of Dr. Brandt's letter, with background information, are attached to our statement as Appendix 2. This material clearly demonstrates that NIOSH is appropriately exercising its authority to notify workers of occupational disease risks.

Employees and their representatives are also routinely involved in both MSHA and OSHA enforcement activities, inspections and investigations. Similarly, employee representatives are provided the opportunity to accompany NIOSH investigators during site visits and research projects. Further, OSHA, NIOSH and MSHA routinely provide employees and their representatives with notice of their right to participate, and of the results of their enforcement and research projects.

In addition to the extensive communication efforts involved in these programs, it must be emphasized that employee exposures to potentially toxic substances are limited to safe levels by OSHA and MSHA permissible exposure limits. Violation of these exposure limits carries potential civil and criminal penalties. And, Mr. Chairman, you are well aware of the extensive worker compensation and tort liability costs associated with over-exposures to toxic materials. Not only do employers have a responsibility to protect their employees, they have a financial duty to their shareholders to avoid the potential for extensive liability. As you know, this liability has proven its disastrous financial consequences.

For all of these reasons we believe that the notification and prevention goals of S. 2050 are currently being met without the legislation and the potential difficulties that its enactment would create. To add another layer of federal government involvement is totally unwarranted. Dr. Kluck will now address the notification and intervention scheme proposed in S. 2050.

Good morning Mr. Chairman and members of the subcommittee. Although well intentioned, many provisions of S. 2050 are vague. The employee notification scheme is the basis of the bill and illustrative of its vagueness and potential for unintended, serious and troubling consequences.

The bill establishes a notification and intervention scheme by defining worker populations "at risk" of incurring occupational diseases. This term is defined as groups with a 30% greater chance of incurring disease than comparable workers not so exposed. This definition is used to trigger the bill's notification and prevention strategies.

First, we do not understand whether the bill is intended to cover current and future employees, or whether it is intended to include all past employees as well. Although we have severe problems with S. 2050 in either case, to the extent that past employees are intended to be covered, it becomes increasingly more complex and disturbing.

Although the simplistic nature of the definition may have popular appeal, its vagueness is disastrous from the viewpoint of those of us in professions related to the prevention of the occurrence of occupational disease.

Any specific excess risk factor may not be "statistically significant" and worthy of action. Important factors effecting the excess include: (1) the nature of the study upon which it is based (e.g. human vs. laboratory or animal studies); (2) the number of persons studied and its representativeness of the population that the study group is supposed to be representative of; (3) the representativeness and number of persons in the control group that is being compared to the study population; (4) the substance being studied and the uniqueness of the exposure to the study population versus the control group and the general population; (5) the internal study controls that would eliminate the effects of confounding exposures for other substances or processes that may produce the same health effect or act synergistically with the substance being studied; (6) the accuracy of the

diagnostic process for the health effect being studied; (7) the accuracy of the exposure measurement techniques for the substances under study; (8) the validity of extrapolating from health effects of measured exposures to much lower exposure levels; and (9) whether the study clearly demontrates an occupationally induced disease, or if the risk results from non-occupational exposures.

Complicating this analysis is the distinction in reliability between morbidity (illness) studies and mortality (death) studies. Morbidity studies often involve questionnaires with, at best, suspect results. They are much more subjective than mortality studies and are thus recognized as being less reliable for demonstrating statistically significant excess risks.

These are just some of the factors that must be analyzed before a professional in our preventive business would decide whether or not to attach significance to any excess risk factor.

Lung cancer studies are a common and excellent example. In addition to requiring stringent controls for confounding exposures such as cigarette smoking or asbestos, studies for substances suspected of causing lung cancer are often not considered to have statistically significant results unless they find excess standard mortality rates of 300 to 400. The 30% excess risk, described by S. 2050, will not be statistically significant for most of these mortality studies, and much less so for morbidity studies that are even less indicative of true risks.

Furthermore, merely defining a population group by virtue of an excess risk factor does not provide the correct parameters for notification of employees who are truly at excess risk of contracting an occupational disease. A short illustration can demonstrate this as one of the bill's major flaws.

A number of years ago, NIOSH conducted an epidemiological study of silica exposures at a silica sand operation where employees were exposed to respirable silica dust at many times the allowable regulatory limits. Naturally, the study clearly

demonstrated that the population at that specific site was significantly at risk of contracting disabling silicosis. If a risk analysis had been performed, it would certainly have resulted in greater than a 30% excess risk or even greater than the 100% excess risk factor as required by the House companion bill, H.R. 1309.

Unquestionably, the employees at that specific site should have been notified of the risks they were undertaking, and we believe that NIOSH did, in fact, notify them or their labor representatives.

Present law and regulation would require notification if the study were conducted today. However, S. 2050 could also require notification of other groups or subgroups of workers potentially exposed to silica, that they, too, may be subject to this "risk" of contracting a disabling disease.

In mining, almost all production employees are potentially exposed to some form and quantity of silica dust because

it is the most common element found in the rock that must be broken and moved to produce mining products. However, the exposures of the employees at the silica sand facility studied by NIOSH had no relationship whatsoever to the potential exposures of the general mining population.

Different mining operations, like different manufacturing processes, result in vastly different types of potential exposures. Yet, both NIOSH studies and MSHA enforcement inspections have clearly demonstrated that almost the entire mining population is well within compliance limits for silica exposures. And, as I'm sure you know, these exposure limits are based on scientific data demonstrating that these controlled exposures, at or below the limit for an entire working lifetime, will not result in the occurrence of disabling occupational diseases.

To notify all current and past miners that they are at "risk" of contracting disabling silicosis would be factually incorrect, costly, and emotionally distressing to them. Yet,

S. 2050 could well produce this unintended and extremely counterproductive result.

Our concern with the potential emotional distress of employees should not be taken lightly. Only last January, American workers, and the American public in general, were subjected to a wholly unwarranted and misleading report alleging government suppression of evidence that over 200,000 workers were at increased risk of developing workplace induced cancer, lung disease, heart disease and other health problems.

The report, issued by the Public Citizen Health Research Group (Public Citizen), and referred to earlier in our testimony, purported to be based solely on documents provided by NIOSH in response to a Freedom of Information Act request by Public Citizen.

In fact, much of the report contained Public Citizen's own speculations as to potential diseases arising from exposure

to various workplace agents, even though Public Citizen had no idea of the extent of such exposures.

The nature and scope of the NIOSH studies cited by Public Citizen were not explained in the report. Thus, it was impossible to determine: (1) whether the studies involved workplace exposure measurements or medical surveillance; (2) whether the studies found any excess risk of illness; and (3) whether the excess risk of illness, if any, was due to occupational, as opposed to other, causes.

Additionally, the report was rife with reporting errors as to the workplace locations, number of workers involved, and whether or not the workplaces were still in operation.

This misleading report, coupled with its wide dissemination in the press, raised unnecessary fears among American workers, including miners, and demonstrates the ethical and moral implications of any notification system.

AMC relayed its serious concerns with the Public Citizen report in a letter to NIOSH Director Dr. J. Donald Millar, and we ask that this letter, Appendix 3, also be made part of the record.

Similar horror stories of inappropriate notification have occurred before, can be expected again and may be sanctioned unwittingly by S. 2050. The only solution that the bill presents is that decisions on modifications would be made by a "Risk Assessment Board" and reviewed by the Secretary with possible appeal to the courts. However, necessary and appropriate administrative procedures, such as hearings with the right to cross-examine witnesses, and the development of a certified record for circuit court review are missing. Complicating appellate court review even further is the short 30-day period during which costly litigation decisions must be made.

Mr. Chairman, as with all difficult problems, there are no easy solutions, and the creation of another board or committee will not in any way substitute for the professional judgment that

must be used to evaluate the validity of research studies. And, the short circuiting of normal rulemaking procedures by eliminating hearings and cross examination makes faulty notification even more likely.

To summarize, the notification triggering mechanisms of S. 2050 are inappropriate. They are not based on the existence of a statistically significant risk that can be validly extrapolated to the group of workers to be notified. They are triggered without standard procedural safeguards, and court review is impinged upon by the lack of a certified record and the short time frame for filing appeals.

Finally, we have not yet had the opportunity to assess the potential cost of S. 2050. The bill's direct costs of identification and notification, although potentially excessive, may be minuscule when compared to potential increases in health care and insurance costs resulting from unneeded and ineffective medical monitoring, or inappropriate medical intervention. We are

conducting a study to determine direct costs, and we hope to forward it to you for inclusion in the record.

Additionally, notification of employees comes with a significant risk of indirect costs due to potentially unjustified liability claims, both within and outside of the workers' compensation system. The potential for such claims may be acceptable when notification is truly justified. However, to inadvertently encourage unfounded claims through an inappropriately designed and unneeded notification system will undoubtedly be a serious threat to the viability of American industry.

We understand that a NIOSH pilot program for notification based on a retrospective mortality study resulted in immediate and extensive litigation. Mr. Chairman, you are very much aware of the thousands of previously approved and pending black lung claims, even though only 5% of them or less are warranted and approved under current proof requirements. You are also aware of the extensive asbestos litigation, even though much of it is also unwarranted. To inadvertently encourage a national epidemic of

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unfounded claims would be devastating. Mr. Roy will conclude our testimony.

Mr. Chairman, you have seen the rapid erosion of our industrial base and the ever-rising spiral of compensation and insurance costs. The survival of what is left of America's basic industries is dependent upon our competitiveness in world markets. Undertaking the program described by S. 2050 could place a severe economic strain upon us without any corresponding health gains. We respectfully request that you seek a prospective study of the cost and benefit of S. 2050, prior to its enactment, from either the General Accounting Office or the Office of Management and Budget. We also suggest that you request these two agencies to survey the potential for unnecessary litigation that would be created by the bill.

Mr. Chairman, we believe that S. 2050 is both unnecessary and poorly designed. Although we are in complete agreement with the goal of protecting the health and safety of our nation's workforce, we are strenuously opposed to this bill. We hope that

you will not report it to the full Committee nor carry it to the floor of the Senate.

We appreciate this opportunity to provide you with our views, and would be pleased to provide any further information you might find helpful.

Senator NICKLES. If you would kind of quickly—we are in a real time bind.

Dr. KLUCK. OK. Although well intentioned, the provisions are vague, and they carry the potential of unintended serious and troublesome consequences.

It appears the bill is intended to cover current, future, and all past employees, and this is a problem. In addition, defining worker populations at risk is a problem, how to define the person at risk. First of all, we are saying that a 30-percent excess is at risk. In reality, they may not be at risk, even though they may be exposed; 30 percent is often so low that it is really not significant, and is meaningless. The bill does not address this.

Second, without including clear directions to the Risk Assessment Board as to need to review factors, including nine factors that we put into our written form, the bill is fatally flawed.

The other factors—defining a population group by virtue of an excess risk factor does not really provide the correct parameters for notification of employees, because they may not be truly at excess risk, as this bill is trying to point out, of contracting an occupational disease.

A few years ago, NIOSH did a study on silica exposure in a silica flour facility, and in this location, these people were exposed to very high doses of silica flour, much more so than the regulations allowed Now, these people obviously were at high risk, and they were, I think, notified immediately of the risk involved. And certainly, we would have gotten over a 30-percent risk factor involved in this.

The present law that we have now and regulations would require these people to be notified. So we are already covered there. This bill, however, could also require notification of all silica-exposed workers.

Now, in the mining industry, nearly everybody is potentially exposed to silica to some extent. After all, silica is the main element found in the rock that we break and move in order to get our products. But these people are not really at risk under that NIOSH study because the concentration of respirable silica is so low as to be well within the acceptable range of not creating a risk. And these levels are based on studies which are done to prove scientifically that they are not at a high risk.

Senator NICKLES. Dr. Kluck, could I interrupt you and ask you a question that I will ask our other panelists as well. I have heard you mention this excess risk and the fact that maybe there would be a lot of people who would be notified which, in your expert opinion, would not be at risk; is that correct?

Dr. KLUCK. That is correct.

Senator NICKLES. I have heard Senator Metzenbaum say once or twice that he is open for suggestions. Do you think that could be amended in a way which would actually get to the point of notifying those persons who actually have a health risk? In other words, do not notify hundreds of thousands of people when their chances of being at risk from some type of occupational disease is de minimis. Actually contact those individuals who may have come under a great deal of exposure that may have given them incidence at the beginning of some type of disease that they need to find about so

that first, they will be aware of it, and second, possibly take some preventive action on it. Are there any suggestions along that line?

Dr. KLUCK. I think this is already being done through the MSHA, and OSHA, and NIOSH people.

Senator METZENBAUM. Well, I would like to say to you with respect to the chairman's question, I do not have any special pride of authorship. If any of your groups have some suggestions as to how we can make the bill a better bill, that is fine with me. We are not trying to place any undue burden on industry or on any other segment of our society. So if you do have, please feel free to work with my staff, and I would be happy to work with you, too.

Senator NICKLES. Dr. Gaffey, did you want to comment?

Dr. GAFFEY. Yes; I think I can talk around your question; I am not sure that I can answer it.

Senator NICKLES. That is what Senators usually do.

Go ahead.

Dr. GAFFEY. A philosopher is a man who, when asked a question, makes a distinction. I would like to distinguish between the issue of determining whether there is an excess risk and determining whether to inform. I think both of these are more complicated than appears to be the case. And certainly, without prescribing what should be done, if I were to try and characterize excess risk, I would certainly take into account first of all the size of the risk; second, the statistical significance of the risk. In other words, that would tell me whether or not it is real.

In deciding whether to notify, I would probably also want to take into account what percentage of the population were affected and what benefits I could expect from the intervention. And I do not know how to specify either of these two things, but it seems to me that these two elements have to be looked at, and more attention has to be paid to them.

The people at CDC have done a good deal of thinking about the first of those issues, and it might be well to see what they say, although it is true that what they have to say is complicated, and I am not sure how easy it would be to prescribe that in a bill. But certainly, I think that is one of the issues that has to be addressed. The other one is the notification issue.

Senator NICKLES. Senator Metzenbaum.

Senator METZENBAUM. I have no further questions, and I thank the panel for their help.

Senator NICKLES. To our panel, we do thank you. I have heard individuals state that some of the problems they have with this legislation is that it looks to be a very shotgun approach, or we are going to be doing a lot of notification, when maybe there is not real risk there. I do no know whether that definition of determining who is really at risk could be more pointed.

But like Senator Metzenbaum, I would welcome your suggestions along that line.

Thank you very much.

Senator METZENBAUM. I have some questions to submit to you, also.

Thank you very much.

Senator NICKLES. Thank you.

Our next panelists are Charles Coakley, senior counsel for the American Insurance Association, and John Abbott, legislative counsel for Liberty Mutual, representing the Health Insurance Association of America.

Senator METZENBAUM. I wonder, Mr. Chairman, if we might bring Mr. Winpisinger to the table at the same time. He might have a different point of view. But I pay dues to his union as a member, and I am concerned that if we do not get him on before I leave, he may refuse to permit me to continue to pay dues to his organization.

Senator NICKLES. That will certainly be all right. Mr. Winpisigner, please come up. They might increase your dues, too, Senator Metzenbaum.

Senator METZENBAUM. He is capable of doing that. I want to say to all the members of the panel that I absolutely must leave here about 7 minutes to 12. I hope that each of the panel members might confine their remarks to no more than 4 or 5 minutes so that I have a chance to at least get an overview of what you are each saying.

Senator NICKLES. Mr. Coakley.

STATEMENT OF CHARLES A. COAKLEY, SENIOR COUNSEL, AMERICAN INSURANCE ASSOCIATION, NEW YORK, NY, AND JOHN L. ABBOTT, LEGISLATIVE COUNSEL, LIBERTY MUTUAL INSURANCE CO., BOSTON, MA, ON BEHALF OF HEALTH INSURANCE ASSOCIATION OF AMERICA, ACCOMPANIED BY PATRICK L. CARMODY, ASSOCIATE CORPORATE COUNSEL, MUTUAL OF OMAHA INSURANCE CO.

Mr. COAKLEY. My name is Charles Coakley. I am with the American Insurance Association, which is a property casualty trade association of 171 members. We write about 50 percent of the workers' compensation insurance business in this country, and thus S. 2050 is of great interest to us.

I will not go into great detail. My statement is in the record. But I do want to reiterate a few of the things, and maybe one or two things that have not been brought up this morning.

Of course, we support the idea of the bill. The bill, we submit, is flawed. It could be fixed. It could be made in such a fashion that we could support it. There are some very good things in the bill.

The problems with the bill, of course, No. 1, is the bad science of the 30-percent standard. Why not 25? Why not 35? What is magic about 30? You have heard from other people, epidemiologists, that 30 is woefully lacking in some instances and too broad in others.

Also, too, the duplication is a problem. It is needlessly expensive. OSHA is already working in this area. This bill, S. 2050, would put the enforcement and whatnot under a different Secretary, not the Secretary of Labor, but the Secretary of Health and Human Services.

If, as has been said earlier this morning by several people, OSHA is not doing the job, make them do the job. I cannot imagine that a Government agency will not do what the Congress tells it to do. I think that it is needlessly duplicative to create a whole new thing

in another agency, and if OSHA is not doing it, what guarantee is there that Health and Human Services will?

Legal diseases goes along with the 30 percent. You look at causation in a particular group. Just looking at incidence of disease and a lot of other things, you are going to have built-in presumptions that just simply will not work.

One problem that has not been mentioned is that the bill states in 9(e) that, "Notification pursuant to this Act"—notification of the workers that they are exposed to whatever they are exposed to—"shall not be relevant in determining whether such a claim is timely under any applicable statute of limitations." That conflicts with about 32 or so State occupational disease statutes of limitations. We think they are pretty good statutes of limitations, which do not run from the last day that the worker was exposed to a substance that may cause disease, but begins to run either 1 or 2 years, mostly 2 years, from the date the worker is disabled and knew or, in the exercise of due diligence, should have known, of the disease and its relationship to employment. That can be 5, 10, 15, 20 years down the road——

Senator NICKLES. Could you state your initial sentence, on where it was not——

Mr. COAKLEY. It is in 9(e), "Notification pursuant to this Act. . . ." Let me just get the——

Senator NICKLES. That is all right. I just wanted to make sure. You are saying that would contradict a lot of State workers' comp laws?

Mr. COAKLEY. Yes. It is on the bottom of page 19 of the bill, beginning with line 23.

Senator METZENBAUM. Would the insurance industry be interested in working out such matters as that, which we would be willing to do?

Mr. COAKLEY. Yes, we would. And I would like to conclude briefly by saying that I am a great fan of the Occupational Environmental Health Centers that are in this bill. This is something that is necessary. We have a whole lot of undiagnosed occupational disease—maybe we do—in this country; people say there is some, but you do not know for sure. And there is some expertise in some States that may be lacking in other States. Some entity like this, which would investigate, set up standards which could be used for workers' compensation boards throughout the country, to properly decide and award occupational disease benefits. That is a goal that we support. It is something that is very difficult to get a handle on. Everyone knows if you fall off a ladder and break your leg, that is work-connected, and you get paid. If someone is working with silica dust or exposed to coal or whatever, and they come down with a lung disease, is it related to the occupation, or is it not? There is a lot of diversity of opinion there; there is a lot of litigation that goes on. I would like to see that eliminated. And these health centers' research go in the right direction—except, of course, that they should not be using things like a 30-percent standard. They should use proper scientific epidemiological studies, and that part, we support.

Senator NICKLES. Thank you very much for your comments.

[The prepared statement of Mr. Coakley and response to a question submitted by Senator Nickles follow:]

STATEMENT OF THE AMERICAN INSURANCE ASSOCIATION

TESTIMONY

OF

CHARLES COAKLEY, SENIOR COUNSEL

AMERICAN INSURANCE ASSOCIATION

MAY 15, 1986

BEFORE THE SUBCOMMITTEE ON LABOR

OF THE

SENATE COMMITTEE ON LABOR & HUMAN RESOURCES

ON

S.2050 - EMPLOYEE RIGHT TO KNOW LEGISLATION

American Insurance Association

The American Insurance Association is a national trade organization of casualty insurers.

My name is Charles Coakley. I am Senior Counsel with the American Insurance Association, a property casualty insurance trade association of 171 members. Our members write approximately 50 percent of the workers' compensation insurance business nationwide, and thus have a vital interest in S. 2050, a bill that deals with occupational disease.

At the outset I want to state that we are not opposed to the concept of the bill; that is, the notification of workers that they are working with substances which may cause illness. We do, however, object to some of the methods the bill uses to accomplish this end.

We believe that S. 2050 is an improvement over H.R. 1309. Some of the objectionable parts of H.R. 1309 have been eliminated but some others still remain.

S. 2050 needlessly duplicates considerable effort already under way. Many states have enacted right-to-know laws which require employers to post a list of substances used in the workplace. On the federal level there is the Occupational Safety and Health Act (U.S.C. 29 §651 et seq.). This act, dating from 1970, in its statement of purpose sounds much like S. 2050's statement of purpose. We find for example:

1. encourage employers and employees to reduce the number of occupational safety and health hazards.

2. authorize the Secretary to set mandatory occupational safety and health standards.

3. provide for research in the field of occupational safety and health.

4. establish causal connections between diseases and work.

Comparing the O.S.H.A. Act and S. 2050 we find that two different cabinet secretaries would be involved. The Secretary referred to in O.S.H.A. is the Secretary of Labor, while in S. 2050 the Secretary is the

Secretary of Health and Human Services. We believe that it is impractical, as well as overly expensive, to have two different departments working in the same area.

The bill would have the effect of establishing "legal diseases." Such a disease is established by presumptions which state either that exposure to a certain substance shall be presumed to cause a certain disease or, as is done in the bill, a provision which states that if a disease occurs at a rate 30 percent greater in one group as opposed to another group, that increase defines the one group as a population at risk. Instead of looking for true causation, we establish a legal disease.

An example will illustrate the problem with using a percentage incidence as a determinant. Assume two groups of workers in a similar type of manufacturing. The pressure to produce the goods is intense. There is a lot of overtime and a lot of stress in both groups. The definition of "hazardous occupational exposure" would include stress. Assume that the rate of heart attacks was 30 percent greater in one group than in the other. By the terms of the bill the group with the higher amount would be deemed a population at increased risk. However, when we come to examine the makeup of both groups, we might find that the group with the higher incidence has workers who are in their fifties and sixties and who smoke and drink more than they should, while the group with the lower incidence are workers in their twenties and thirties who smoke and drink less. Smoking, drinking and stress are known causes of heart trouble, yet the bill would look only at a result and not the true cause.

If the Risk Assessment Board uses the 30 percent standard we believe that there would be a considerable amount of needless worry among many workers because of the notification procedures. Many occupations have peripheral contact with substances that can cause disease. Other workers have considerable contact with such substances, yet we see that only a small number of them become ill. Even something as dangerous as asbestos disabled only a fraction of all who come in contact with it. Workers who were notified might not be aware that existing safety precautions had reduced the chance of disablement or that very few would be affected. Their families and communities would be alarmed out of all proportion to the real danger.

This worry might lead to a considerable use of unnecessary medical care and could mislead people into filing workers' compensation claims when there was no disability. We have no objection to claims for actual disability, but we can expect that the state workers' compensation systems would be inundated with claims because of the fear of becoming disabled.

We would like to point out that Section 9(c) would severely impact individual employers and employees. That Section states that the cost of testing, evaluation and medical monitoring shall be included as a covered item in any health care financing system. Employees with exposure but no illness would be monitored for years. All employees with exposure would be evaluated and reevaluated at periodic intervals. Many employers pay the full cost of employee health insurance; other employers pay part ofthe cost and their employees pay the other part. There is no doubt

that the cost of health insurance would increase dramatically if S.2050 were enacted.

We think there is considerable merit in the creation of the occupational and environmental health centers. The expertise that these centers would provide may exist today but it is unfocused. Recognition, diagnosis and treatment of occupational disease on a nationwide basis is a worthy goal. We want to stress however, that the health centers must use proper scientific standards and not arbitrary figures (such as the 30 percent incidence).

Finally, we would like to point out a problem found in Section 9(e). The last sentence states that: "Notification pursuant to this Act shall not be relevant in determining whether such a claim is timely under any applicable statute of limitations." Many states occupational disease laws provide that the statute of limitations begins to run from the date the employee knew or should have known of his disability and its relationship to employment. The last sentence of 9(e) would extend such a statute forever because the employee would know why he was disabled and be under no obligation to file a claim.

In closing, we would like to reiterate that no one objects to workers knowing what their exposures are. We submit that S. 2050 is flawed, as we have outlined. We thank you for this opportunity to present our views.

AMERICAN INSURANCE ASSOCIATION
85 John Street
New York, N. Y. 10038
(212) 669-0400

June 13, 1986

Charlene Abshire
United States Senate
428 Dirksen Senate Office Building
Washington, D.C. 20501

RE: S. 2050

Dear Ms. Abshire:

I do not think that Section 9(d) of S. 2050 should be eliminated from S. 2050 but it should be rewritten so that its purpose is clear.

As I understand it, (d) was included to take care of the following situation. A worker becomes sick and goes to his doctor who treats him. The worker does not initially know that his illness is work connected. His bills are thus paid by Blue Cross or some other health insurer. In time the worker finds out that his illness is work connected and he then files a workers' compensation claim. The health insurer should be reimbursed by the compensation insurer, but this does not always happen. I suggest that (d) be rewritten:

> "If an employee has been provided treatment by a health care financing system for a disease which is the basis for a successful state or federal workers' compensation claim, the health care financing system shall be reimbursed the cost of the treatment by the provider of workers' compensation benefits."

Yours sincerely,

Charles Coakley
Senior Counsel

CC:af

PETER LARDNER, CHAIRMAN EDWARD H. BUDD, VICE CHAIRMAN DeROY C. THOMAS, VICE CHAIRMAN T. LAWRENCE JONES, PRESIDENT

Senator NICKLES. Mr. Abbott.

Mr. ABBOTT. My name is John Abbott. I work for Liberty Mutual Insurance Co. in Boston. With me today is Patrick Carmody, from Mutual of Omaha. Together, we are representing the Health Insurance Association of America, a group of 300 insurance companies that together write about 85 percent of the private health insurance in this country.

In general, like many of the other witnesses, we support the objective of this bill. Occupational disease is a subject that we have put off far too long. The Government has been making efforts, but it has not been enough, obviously.

Our principal concern surrounds the ability of our industry to underwrite these risks. In order for us to price the product that we are going to charge the employer, we have to know who we are covering. And, as you heard today, the type of science that is involved in determining who is notified, in our opinion, is not really satisfactory for us to make an accurate prediction of who we are going to cover.

In terms of workplace exposures, there is no substitute for on-the-spot inspection of the workplace. We know what a chemical can do to persons if they are subjected to it, but we cannot make a determination about a specific person and the effect of the chemical on that person until we examine the workplace environment. And we feel that until some provision is made whereby we can be certain about who we are covering, it is going to be very difficult to underwrite this type of coverage.

We have an additional concern that if we were to identify the persons that we are supposed to be monitoring for occupational diseases, the provision in the proposed legislation which prohibits discrimination on the part of an employer or any other representative, discrimination against the person who has been notified of occupational disease, we are concerned that this provision may impact our ability to charge the additional cost that this will obviously engender. That is a problem for our industry.

Two other points that I think Mr. Coakley began to allude to concern the relationship between occupational disease, which is generally covered by workers' compensation laws, and health insurance, which contracts generally exclude workers' compensation-type injuries. Under the proposed legislation, we can envision a situation where a worker who is notified that he is at risk would require and expect to be monitored.

The health insurance contract basically excludes any coverage for a workplace injury. Likewise, the occupational disease is covered by the workers' compensation contract.

Section 9(d) sets up a subrogation procedure which we believe would not work unless you amend the State laws that currently cover workplace injuries and occupational disease.

I think, in very short summary, the subject that we are concerned about in this area is the confusion that would arise over imposing a Federal law on top of a State system which has 50 individual laws. That perhaps could be worked out, but it is not handled adequately in this legislation and would create a situation that could lead to more litigation and expense for the employer.

Senator METZENBAUM. Mr. Abbott, I want you and Mr. Coakley both to know, as well as the other gentleman, whose name I do not know, that we would be very receptive to meeting with you and talking with you to see whether or not we can make some progress forward. I do not think that we are on opposite sides of the track, and if you have time today and want to wait around, Mr. Brudney will be very happy to sit down with you and talk about something specific.

Mr. ABBOTT. I think we would, yes, Senator.

Senator METZENBAUM. We really appreciate your testimony, yours and Mr. Coakley's.

[The prepared statement of Mr. Abbott and responses to questions submitted by Senator Metzenbaum follow:]

STATEMENT OF THE

HEALTH INSURANCE ASSOCIATION OF AMERICA

on

The High Risk Occupational Disease Notification and Prevention Act (S. 2050)

Presented by

JOHN L. ABBOTT

and

PATRICK J. CARMODY

BEFORE THE

LABOR SUBCOMMITTEE

COMMITTEE ON LABOR AND HUMAN RESOURCES
UNITED STATES SENATE

May 15, 1986

I am John L. Abbott, Legislative Counsel of the Liberty Mutual Insurance Company of Boston and accompanying me here today is Patrick L. Carmody, Associate Corporate Counsel of the Mutual of Omaha Insurance Company. We represent the Health Insurance Association of America (HIAA), a trade association representing 335 insurance companies. Our members write over 85 percent of the private health insurance provided by insurance companies in this country.

Our testimony today will focus primarily on the impact of S. 2050, the High Risk Occupational Disease Notification and Prevention Act, on insurance practices and principles. The bill would create a new federal program which would be required to identify groups of employees exposed to occupational hazards where the risk of a particular disease is some increased percent of the national average. Employers, insurance companies and others would be precluded from discriminating against such employees, and health insurance companies would be required to pay for periodic medical monitoring and evaluation of the health of such employees.

Certainly, we have no objection to the general thrust of S. 2050, that workers should be informed of the risks of contacting occupational disease as a result of employment, particularly when early medical intervention can reduce the effects of occupational disease. Insurers strongly identify with the objective of

determining if any hazard, occupational or otherwise, increases the exposure of a person to disease.

However, the HIAA has considerable concern over the practicality and workability of the insurance-related provisions of S. 2050. And we object on the basis of fundamental insurance principles to certain concepts underlying this legislation as they affect our business.

S. 2050 contains provisions that would mandate certain insurance coverages in group insurance contracts (Sec. 9(b) and (c). Optional coverage would be available for individual purchases of insurance. These provisions require insurers to cover medical monitoring and testing expenses for workers found at risk of occupational related diseases. While the HIAA supports the concept of preventive health care benefits, we believe that the decision to offer such benefits should be left to individual companies in response to competitive market forces. HIAA opposes the imposition of insurance benefits through government mandate.

HIAA fears that mandating one particular benefit, however meritorious, will set a precedent for others which may appear equally valid. A proliferation of mandatory coverages may well cause some employers, particularly small or marginally profitable ones, to drop what coverage they currently provide, leaving their employees, spouses and children with no coverage at all.

Also, by mandating benefits the proposed bill directly interferes with the collective bargaining process. Employers and labor/management trust funds have finite resources available with which to purchase employee benefits. Mandated benefits narrow the choices available to the employee bargaining unit and the employer by forcing them to purchase a particular benefit. Picking the right benefits for each group should be left to the group themselves and their employer. They are in the best position to determine what types of coverages are needed. It should be noted that insurers frequently offer preventive health care and related benefits through this process.

The proposed Act also seems to blur the distinctions between health insurance and workers' compensation and between occupational and non-occupational illnesses. Group health insurance plans universally exclude expenses in connection with occupational disease. The costs of non-occupational disease are, of course, traditionally financed by health insurance. If the mandated preventive medical regimen contained in this law is related to the threat of occupational disease, we question whether payment for this medical surveillance is the proper responsibility of health insurance. Since the very nature of this law implies a relation of high risk occupational disease to employment, it is also possible that the costs of monitoring health of such a worker would be determined to be occupational and thus excluded by contract from health insurance coverage.

We further note that monitoring and testing of "at risk" employees who may be exposed to potential health hazards is a very ambiguious requirement, and it would be difficult for insurers to determine the validity and necessity of such procedures ano the frequency of their use. The cost impact of such monitoring could be significant.

In addition to the above, there are several aspects of S. 2050 which would make it difficult for insurers to comply with the procedures envisioned.

Scientific Impracticality - A key to making S. 2050 work lies in the ability of a Risk Assessment Board within the National Institute for Occupational Safety and Health to determine an employee who is at "increased risk" or "high risk" of developing an occupational disease. We are informed by occupational health specialists that a fundamental principle of toxicology is that all chemicals are capable of causing disease at some dose. Assessing the risk to an individual working with a chemical involves:

1. Knowing the amount of the chemical likely to cause disease and;
2. Knowing the circumstances under which the individual is involved with the substance in question.

In the opinion of industry loss prevention experts, medical science has not yet advanced to the point where epidemiological studies can provide an accurate quantitative determination of an employee's potential increase in risk. With a few exceptions, data on the effect of chemicals on living human beings consists of anecdotal reports (descriptions of suicide attempts or accidental exposures) and a limited number of dose-response studies, usually involving other species. Further, a working knowledge of the conditions of exposure is vital to determine the likelihood that workers handling hazardous materials will be exposed to harmful amounts of the substance.

In view of the above, it is difficult to imagine how a national or regional risk assessment board could make an accurate determination of how much "at risk" an employee is, let alone make a decision as to which individual employees were at risk at a given time. The difficulty in determining which employees are at risk, (and to what extent) impacts directly on the ability of the insurer to underwrite the risk. Underwriting is based on the ability to predict, with reasonable certainty, the number of cases requiring treatment, the amount of treatment involved and the ultimate cost of the program. If underwriters do not have confidence in the government's ability to determine the number of "at risk" employees, insurance companies will be reluctant to bid on insuring this type of risk.

Discrimination Prohibition - Section 8(a) states (in part) that "no ... insurance carrier ... shall in any manner discriminate against any employee on the basis that the employee on the basis that the employee is or has been a member of a population that has been determined by the Secretary to be at risk of disease." As written, this section could be interpreted to preclude an insurer from charging higher premiums for those employees who, because they require monitoring, increase the cost of providing health insurance. We also are concerned that normal experience rating procedures that may reflect claim increases from monitoring would be judged to be discriminatory under this section. Further, we question whether substandard experience rating due to high risk occupations would be allowed. This Section thus might violate principles of risk classification, which is the basis for the pricing and availability of insurance. The heart of the insurance business is classifying people and things according to risk, and charging premium in light of the risk. Section 8(a) appears to violate this principle.

The definition of "hazardous occupation exposure" in Section 3(7) is far broader than definitions of occupational disease utilized in state workers' compensation statutes today. As drafted, this definition assumes a causal connection between the presence of a hazardous substance in the workplace and the illness rather than requiring actual proof that the workplace exposure caused the illness. Further, it fails to take into account any

non-occupational lifestyle exposures to substances which could be a contributing factor in the occupational disease. Thus, under this definition an employer could become responsible for monitoring employees whose occupation was not the sole or major cause of their medical condition. A definition as broad as this one blurs the distinction between workplace and non-workplace illnesses, violating long-standing underwriting and risk classification practices.

Subrogation - Section 9(d) states that treatment for a subsequent disease "may constitute an insurance subrogation claim against a workers' compensation program or insurance carrier."

As drafted, this provision appears to provide health insurers a means to recoup payments made for monitoring an "at risk "employee from the workers' compensation carrier once the employee actually contacts an illness. This runs counter to all state workers' compensation laws and to current group health insurance contracts.

State workers compensation laws hold an employer liable for work related injuries or diseases only after a determination that the injury or disease has manifested itself and that the workplace exposure was the major cause. On the health side, the standard group health insurance contract excludes payment for any benefits which are covered under workers' compensation statutes. Thus, for the subrogation provision to work state law would need to be changed to allow payment of benefits which were provided prior to the

manifestation of illness. If these state laws are not changed, the subrogation provision would create a situation where a health insurer would sue a workers' compensation carrier to recover payments made on behalf of its client. In turn, the workers' compensation insurer would be defending claims on behalf of its client, the client in both instances being the same entity, the employer. The net result would be an overall increase in claim expenses to the employer.

In summary, we believe that S. 2050, while well intended, is ill conceived as it applies to the insurance business. As outlined in our testimony, the provisions in the proposed Act that relate to insurance violate sound and historic insurance practices. It is fundamentally wrong for Government to mandate types of insurance coverage, impede underwriting of insurance risks, and create health insurance responsibility for occupational risks and hazards.

HEALTH INSURANCE ASSOCIATION OF AMERICA
1025 Connecticut Avenue, N.W., Washington, D.C. 20036-3998, (202) 223-7780

June 5, 1986

The Honorable Don Nickles
Chairman
Subcommittee on Labor
United States Senate
428 Dirksen Senate Office Building
Washington, D. C. 20501

Dear Mr. Chairman:

This responds to the questions submitted to us on behalf of Senator Metzenbaum.

The response to the first two questions follows:

Results of a 1984 survey of coverages provided under group major medical health insurance policies of the commercial health insurance companies indicated that almost 20 percent of the employees reported had coverage for expenses associated with preventive care services. This was a significant increase over the 5 to 12 percent (varying by covered service) reported covered in a similar study conducted for 1980. Expenses for adult periodic examinations were covered for 17 percent of the employees reported, 17 percent had coverage for well-child care expenses (ages 2 to 15), and 19 percent had coverage for well-baby care expenses (under 2 years of age).

The percent of employees covered by size of group did not vary considerably with a range of from 16 percent to 22 percent, higher percentages being associated with the medium and small size groups. No information was captured as to the distribution of coverages by type of industry, or the presence of a union.

The above results represent coverages of the commercial insurance companies. It is estimated that, in total, approximately 120 million persons are covered by these companies for major medical expenses. In terms of employees, they may represent 40 to 50 percent of the work force. In addition to the commercial health insurance companies, major medical expense coverage is available through Blue Cross and Blue Shield associations which may also provide reimbursement for preventive care services and certainly HMO's should be included as providing coverage for preventive care service.

In response to the third question, we would prefer to see the subrogation provision eliminated.

Sincerely,

David J. Pattison

David J. Pattison
Assistant Washington Counsel
& Corporate Secretary

Senator NICKLES. Mr. Abbott, thank you very much. I have read this paragraph on subrogation, and I am still not sure what it means. Would you tell me what you think it means as far as how it would relate to the health and accident insurance industry, as far as coverage?

Mr. ABBOTT. The scheme set up in the legislation would provide that someone is notified that they are at risk. At that point, the health insurer, or the employer through the health insurer, would be required to monitor that person. The legislation then states that once a person actually manifests the disease, then they would be covered by workers' compensation, and the health insurer would be able to subrogate against the workers' compensation carrier.

State laws currently prohibit workers' compensation carrier from paying any costs associated with the disease prior to the actual manifestation of the disease. So it would be impossible for them to pay a cost for something that occurred prior to the time the person became injured.

Senator NICKLES. So the health insurers would be stuck for the monitoring costs.

Mr. ABBOTT. Yes. And that is a very basic reading of it. In fact, we probably would get insurers suing each other in Federal court if this statute went through. That is one possibility.

Mr. COAKLEY. I think I know what the intent of this thing is, and I agree with Mr. Abbott that the drafting is not the best. You see something like this in several State laws, and I think it has been adapted from those. What it means is if you have an occupational disease which is related to your work but you do not know it, and so you go to your doctor, and your doctor is, as I think one of the witnesses said this morning, her doctor was treating her for pneumonia and did not know what was wrong with her. Then, it subsequently develops that you finally find out that what you have is work-connected, but all along, the Blue Cross or the Liberty or whoever has been paying what we call the A&H, the health benefits. Now we find out it is a workers' comp case. At that point, the workers'comp carrier, the employer, should reimburse the health carrier who has paid these bills to date for the amount of money that has happened.

Because that has not been too clear, and there has been litigation in the States, several States have passed a statute that allows that to happen. And I think that is what the intent is here, but I agree with Mr. Abbott, and I believe it was Mr. Willmore, who said that there is some confusion in the way this thing is written, and it could lead to needless litigation. But again, it can be fixed.

Senator NICKLES. OK. Senator Metzenbaum, do you have any questions?

Senator METZENBAUM. Yes, I will submit some. But I do hope they can meet with Mr. Brudney to see if we can resolve some of these concerns.

Senator NICKLES. Gentlemen, thank you very much for your appearance before the committee today.

Our next panelist is William Winpisinger, who has been before us on several occasions. Welcome again before our committee, Mr. Winpisinger.

STATEMENT OF WILLIAM A. WINPISINGER, PRESIDENT, INTERNATIONAL ASSOCIATION OF MACHINISTS & AEROSPACE WORKERS, WASHINGTON, DC, ON BEHALF OF INDUSTRIAL UNION DEPARTMENT, AFL-CIO, ACCOMPANIED BY PEGGY SEMINARIO, AFL-CIO, AND SHELDON SAMUELS, INDUSTRIAL UNION DEPARTMENT

Mr. WINPISINGER. Thank you, Mr. Chairman. It is clearly a pleasure to be here. I represent the International Association of Machinists, and in this case, the AFL-CIO as well as the Industrial Union Department thereof.

Let me say, when consulting our testimony, I think you will find due concern for brevity. We have tried to make it as concise and as pungent as possible, in the interest of the valuable time of the committee, and I will condense that even more as I briefly describe it now.

First of all, we in the labor movement absolutely support S. 2050 as a minimum program that a compassionate and concerned society must engage in out of concern for its workers.

There is no doubt that many, many occupations have already been identified as creating risks, and there are many as yet undetected diseases. And this calls for a program, a national program, which we desperately need to focus on.

It is clear that early discovery of workers at high risk of disease and a prompt monitoring of their condition can get them into medical monitoring and treatment programs that minimize the ultimate damage and give them an opportunity—a better opportunity—to live long and useful lives as any other citizen might.

These disorders and diseases are of the most serious kind, up to and including cancer, nervous, and brain disorders, reproductive damage, miscarriages, birth defects, and many others.

I could run through a whole list of imperatives, but suffice it to say they are in the testimony, and they focus on life and death, literally, of workers in this country. It is a serious and complex problem. And may I say that we believe that this bill is not "pie-in-the-sky"; it is not a Christmas tree-decorated sort of a thing that seeks to penetrate the sound barrier in pursuit of the problem. It is a barebones, nuts-and-bolts, kind of a program that we need now to begin getting on top of what is going to happen to workers 25 or 30 years down the road.

Opponents of the bill have claimed that OSHA already has a program and a mechanism by which to tackle the problem. We do not believe that is accurate, because the OSHA standard is designed to communicate the hazards of chemicals to workers, for example, but does not require focusing on the risk at occupational disease, and that is one of the imperatives in this bill, to get at these very serious diseases, oftentimes long delayed before manifesting themselves with the workers.

So we again think that this is a doable program by Federal Government. We think it is urgent, we support it, and we think it is a minimal, orderly way to go about a very serious problem.

Senator NICKLES. Thank you very much for your comments.

[The prepared statement of Mr. Winpisinger follow:]

STATEMENT OF WILLIAM A. WINPISINGER

PRESIDENT, INTERNATIONAL ASSOCIATION OF MACHINISTS AND AEROSPACE WORKERS

BEFORE THE

SUBCOMMITEE ON LABOR
COMMITTEE ON LABOR AND HUMAN RESOURCES

UNITED STATES SENATE

ON

THE HIGH RISK OCCUPATIONAL DISEASE NOTIFICATION AND PREVENTION ACT (S. 2050)

May 15, 1986

Mr. Chairman, members of the Subcommittee. My name is William Winpisinger and I am the President of the International Association of Machinists and Aerospace Workers. In addition to my own union, I am here today representing both the Industrial Union Department of the AFL-CIO and the AFL-CIO, itself.

At the outset let me say that organized labor strongly supports S. 2050, the High Risk Occupational Disease Notification and Prevention Act. We urge you and your Subcommittee to consider this legislation as expeditiously as possible. We believe that this bill is essential if we are to successfully address the complex set of problems associated with occupational disease in the United States.

As you are well aware, millions of workers are regularly and needlessly exposed to toxic chemicals, wastes, fumes, dusts, and industrial processes as an integral part of their jobs. Over time, such exposure causes a variety of occupationally-related diseases, such as cancer, heart disease, nervous and brain disorders, reproductive damage, miscarriages, birth defects in workers' children, and a host of others.

The exposed occupational populations include millions of workers exposed to cancer-causing substances or processes, including:

- 3 million workers exposed to benzene, with a risk of leukemia some five times greater than normal;

- 2.5 million workers exposed to asbestos, many with a risk of lung cancer five times greater than normal;

- o 1.5 million workers exposed to arsenic, many of whom have a risk of lung cancer often two to five times greater than normal;

- o 725,000 workers exposed to chromium and chromate pigments, some with a risk of cancer five to nine times greater than normal; and

- o 1.4 million workers exposed to nickel, some with a risk of cancer five to 10 times greater than normal.

Examples of other non-carcinogenic, but nevertheless dangerous, workplace exposures include:

- o 1 million women workers of childbearing age exposed to chemicals that cause miscarriage and birth defects;

- o 1 million workers exposed to silica dust, at risk of lung disease; and

- o 800,000 workers exposed to cotton dust, at risk of brown lung disease.

These and many other hazardous workplace exposures take a terrible toll on American workers. Some 100,000 die and another 390,000 may be disabled each year from occupational disease. Indeed, of all the cancers that occur among blue-collar workers in the U.S., at least 25 percent are caused by workplace exposures.

In terms of the relationship between toxic workplace exposure and occupational disease, I would like to make the following observations:

First, there is a period of time between exposure and the onset of disease when it is often possible to medically intervene in the biological process of disease to either prevent or, by early detection, successfully treat many disease conditions.

Second, we already know that there are a number of identifiable occupational populations that are at risk of developing disease because of hazardous occupational exposures.

Third, there is a critical need for a national program not only for identifying and notifying workers at increased risk of occupational disease, but also for counseling and medically monitoring entire worker populations.

Fourth, we believe that workers at risk have a basic and fundamental right to know that they have been exposed to an occupational hazard, are at risk of disease, and what steps can be taken to reduce their personal risk.

Finally, through prevention and early detection of occupational disease, the staggering costs of medical treatment and care to the workers, employers and society can be substantially reduced. More important, we can reduce unnecessary death and suffering.

Although many industry representatives have expressed agreement with the concept of notification and follow-up of the high risk worker population, they nevertheless oppose this bill, maintaining that current company and governmental programs and practices under existing law are sufficient to accomplish the task. We do not agree.

While companies with the integrity and ability to conduct a high risk management program should be encouraged to do so, the certification of these companies should not be

left to chance. Union Carbide, Allied Signal, and DuPont, for example, have all been cited by OSHA on notficiation-related issues. Shell and Mansville have been struck by their unions on these issues.

Despite the claims of those industry representatives who oppose this bill, there are no requirements or systems that ensure notification and medical follow-up of workers at high risk of occupational disease. None of the agencies with responsibility for worker safety and health provide for such notification and follow-up in their regulations or programs.

The National Institute of Occupational Safety and Health is mandated by the Congress to conduct health hazard evaluations and research to indentify work-related health problems. In conducting these studies, NIOSH has a policy of transmitting the results to the employer and the union if one exists. With the exception of clinical studies (which are seldom done), NIOSH makes no attempt to contact the workers who are the subject of the study, even though the workers may be at very high risk and the agency has the names and addresses of the individuals.

The Occupational Safety and Health Administration has the responsibility and authority to regulate toxic substances in the workplace. Under the OSHAct, standards for toxic substances issued by the agency must include medical exams where appropriate, and all OSHA health standards issued to date do contain requirements for medical surveillance and most require that workers be notified of the results. OSHA health standards could provide the foundation for a notification of current workers at high risk of disease if other than corporate physicians are involved. Unfortunately, the industrial medical code of ethics does not demand protection of the patient-physician relationship. Moreover, due to the limitation of the standards to specific regulatory problems involving fewer than two dozen toxic agents,

and the highly specialized medical protocols associated with these issues, even current workers would not have the kind of broad-based surveillance necessary for workers at risk. Former workers, of course, are not covered by OSHA standards. Most important of all, OSHA has neither the mandate or skills to design and administer the follow-up program anticipated by this bill.

Opponents of S. 2050 have claimed that OSHA's Hazard Communication Standard, issued in 1983 and scheduled to go into effect this year, requires the notification of workers who are at high risk of disease. These claims are not accurate. The OSHA standard is designed to communicate the hazards of chemicals to workers, not the risk of disease. Specifically the training and education requirements require that employees be informed of the requirements of the standard; operations where hazardous chemicals are present; the location and availability of chemical lists and data sheets; methods used to detect the presence of hazardous chemicals; the physical and health hazards of the chemicals; protective measures; and the details of the employer's hazard communication program. There is no requirement to inform workers of levels of exposure in the workplace, nor to conduct monitoring medical exams of workers exposed to hazardous substances nor to counsel workers about the risk of disease. While this standard may provide workers with additional information on workplace chemical hazards, it does not establish a system for the identification, notification, and monitoring of workers at high risk of occupational disease.

In conclusion, there are currently no regulations, practices or programs to identify, notify and provide medical surveillance of workers who are at high risk of developing occupational diseases. Although a few laws and regulations have begun to reduce some workplace exposures, past and currently uncontrolled exposures continue to cause disease and death at

alarming rates. If enacted, S. 2050 will finally establish a system for notifying workers at high risk and for providing appropriate medical counseling and surveillance.

According to the American Cancer Society and the American Lung Association, enactment of this legislation will go a long way in ultimately preventing cancer and other diseases, which, of course, should be the primary goal of the law. Again, we urge you to consider this legislation as expeditiously as possible and to favorably report it to the Senate floor.

Thank you.

Senator NICKLES. Senator Metzenbaum, do you have any questions?

Senator METZENBAUM. No, I do not, and I am going to excuse myself. I do not mean to be rude to any of those participating. It is just that I must be someplace at 12, and I am going to have to run. Please forgive me for leaving.

I want to again express my appreciation to the chairman, who went out of his way to accommodate me in connection with setting up this hearing, and I am very, very grateful to him.

Senator NICKLES. I am happy to do that.

Mr. Winpisinger, you represent the International Association of Machinists and Aerospace Workers, and there are a lot of outstanding companies that your union represents—I am thinking of aerospace and major manufacturers. As you probably know, my background was in the machine works before I came to the Senate. I was trying to think of how this would apply in a company that uses a lot of industrial-type machinery, lathes, mills, et cetera, that have solvents; various types of cleaning applications, cutting fluids, et cetera; say, Rockwell or Hughes, or any of those would have a large chip-cutting process. They are liable to move through lots of people. Those people may work on a lathe for a period of time, and they may move on, they may not. They may be involved in strictly outside of that area.

XYZ Chemical Co. is going to be required now when they sell—or, the machine tool company—they are going to be required under present law to state, "Here is the chemicals that we are selling you; here is the potential harm; here is the training that you must institute; here is the notification requirements," et cetera. Again, here is, I am going to say, a reputable company that is very concerned, as I think most of our companies are concerned, about the workers' health, long-term, occupational disease. And everybody, I would think, would agree with the objective of trying to minimize that. So when they buy those drums, they see this, and now they come up and say, "Oh, well, this has XYZ chemical in it, and we need to make sure that people are aware that you are not supposed to inhale this, or not to get it around your eyes, or to wash your hands after you use it," or whatever.

How is this going to impact—let us take a major manufacturer that is running through all these people. If the legislation passes as it is today, would notification be required to send to almost everybody that would be working through that plant at a particular period of time?

In other words, if you overheard my comments earlier, my concern was maybe being able to pinpoint those individuals who might have a direct incidence of occurrence that would indicate a degree of probability that there might be some problem, but not necessarily to mail out everybody that happened to be walking through the plant within the last 20 years.

Mr. WINPISINGER. Well, let me first say, Senator, I think I agree with your conclusion. And I have with me, and neglected to mention earlier, Peggy Seminario from the AFL-CIO, and Sheldon Samuels, from the Industrial Union Department, both of whom possess expertise far beyond my own in this field.

Just relating your question to the machine shop atmosphere, we were aware some time ago—and I do not know to what degree this has been alleviated over time—that some 1,500 new chemicals a year were entering our workplaces, and oftentimes little or no knowledge about their ultimate effects on people working with them. In a machine shop, you have all of the caustics for cleaning, you have all of the cutting oils and compounds which are produced of different types of chemicals and you have a lot of subsequent disease.

And it is only over time we learn who is at risk, and I think that is one of the thrusts of the bill which interests us the most, to begin that process of identifying what those risks may be, and at that point, notify those who are thus exposed. And that seems to me to fall far short of a blanket notification of everybody in the world. It seems to me we need ongoing work through an agency like NIOSH to start determining for us—we already know, by the way, many, many of the areas of risk, and that information is currently available, but there is no requirement to follow through.

OSHA, for example—or NIOSH, I should more properly say—often makes a study and makes a determination, and if there is a union involved, they will tell the union what the results are, they tell the company what the results are, but there is no intention nor any methodical program to let the worker himself know that he is at risk. And if there is a union, of course, we can pass that along and try to identify them and get them monitored.

But there is no consistent followthrough, and that is what the bill seeks to develop, a procedure, (a) for identifying who at risk are, and then (b) having done that, notify them; and probably most important of all, (c) to get them together with competent medical professionals to begin monitoring and hopefully developing cures or counteractives for what they are exposed to in order that their lives are prolonged.

Senator NICKLES. All right. Let me make a comment, and then see if anybody else wants to tackle it. But I think you might see where I am coming from. Let us take, for example, a major manufacturing facility, and it may be that they have bought a barrel of XYZ chemical that could be hazardous to your health if you drank 2 gallons of it a day. Under that type of scenario, they would not necessarily want to mail out to every employee of that company for the last 20 years, because it is more than logical that nobody was drinking 2 gallons of it a day.

Ms. SEMINARIO. Senator Nickles, you have hit upon the critical difference between the OSHA Hazard Communication Standard and what, really the high-risk bill tries to do.

The OSHA Hazard Communication Standard, as was described earlier, does deal with the hazards of chemicals and workers who may be potentially exposed are supposed to now receive information from their employers about the hazards associated with exposure. That is basically everybody exposed.

What the high-risk bill attempts to do is to really define the populations at high risk. That might not be everybody who was ever exposed just because they happened to be working in a job. It might be that it is only people exposed for 5 years' time, because

the studies show that it is after 5 years of time exposure in that job that you really are at high risk.

So what this bill attempts to do is to really focus on those very people and the individuals who are at the high risk of developing disease based upon scientific evidence, studies that have been done, and some additional information that may be available from clinical experience.

So that is really the critical difference between the OSHA Hazard Communication Standard and the legislation that your committee is considering.

Senator NICKLES. Mr Samuels, do you have an additional comment?

Mr. SAMUELS. Yes. I would like to follow up on a comment made by President Winpisinger about the third step, which he described correctly as being the most important step—getting people into a system of medical surveillance. That is something that is not covered by OSHA and is inappropriate for OSHA even to consider.

The fact is that the medical requirements in the OSHA standard are not specific to the kinds of medical programs that are necessary to deal with these workers at high risk. Those medical requirements are built around regulatory issues. It is a form of biological monitoring. It is not a form of medical assistance and counseling of the kind contemplated by the bill.

Moreover, you had some very misleading information from NIOSH. The studies that NIOSH refers to were not studies which they initiated nor designed. They were initiated and designed by the labor movement. They were adjuncts to our efforts, and they did not have, unfortunately, full access to all of our information.

For example, on the costs, the fact is that working through the union—the Patternmakers League is a good example—they were able to keep the cost of notification down to $10 a person. That is just one example of information that, apparently, NIOSH does not have, because it in fact is not the primary author of those studies.

Senator NICKLES. I appreciate your comments.

Mr. Abbott, both you and Mr. Coakley talked about the possible problems in debating back and forth who would share the burden, whether it would be the health and accident insurance industry or possibly the comp carrier.

Earlier today the assistant attorney general talked about the possibility of increased litigation. Do you see that as a result if this legislation were to pass in its present form?

Mr. ABBOTT. Yes, in general.

Senator NICKLES. Would it be class action suits, primarily, or both?

Mr. ABBOTT. Well, I suppose that is possible.

Mr. COAKLEY. You would have, assuming that there is this broad shotgun notification that all of us in this room have been exposed—an example I frequently use is a ballpoint pen. Let us assume that 5 years from now someone finds that working with ballpoint pens caused cancer, and all of us who push pens for a living start running out and suing ballpoint pen manufacturers—not necessarily because we are disabled, but because we may become disabled, and we may have some symptoms or we may not,

and the symptoms may be due to something other than working with ballpoint pens.

A good case in point is emphysema, lung disease, which can be caused by working with cotton dust or working in a coal mine. It can also be caused by smoking three packs of Luckies a day for 25 or 30 years. There are many different causes.

But because of what I would consider the fear element, where you go into a workplace—a town, perhaps, or a county where maybe there is one dominant type of industry there—and everyone gets frightened, and everyone runs off—maybe not everyone—but many would run off and file lawsuits.

I would agree with the notification, that the notification should be limited to those who have been exposed sufficiently to whatever it is that may cause something—not a blunderbuss or a shotgun, as is envisaged in this bill.

Senator NICKLES. Mr. Coakley, thank you very much.

To all of our panelists, I appreciate your participation before the committee today. I also have a statement by the Chemical Manufacturers Association, which I wish to have entered into the record at this point, along with additional material subsequently supplied for the record.

[The statement referred to and additional materials supplied for the record follow:]

STATEMENT OF THE CHEMICAL MANUFACTURERS ASSOCIATION ON S.2050, THE HIGH RISK OCCUPATIONAL DISEASE NOTIFICATION AND PREVENTION ACT OF 1986

Submitted to the Subcommittee on Labor
of the Senate Committee on Labor and
Human Resources

May 15, 1986

INTRODUCTION AND SUMMARY

The Chemical Manufacturers Association ("CMA") welcomes the opportunity to submit this statement on S.2050, the "High Risk Occupational Disease Notification and Prevention Act of 1986." CMA is a non-profit trade association whose member companies represent more than 90% of the productive capacity of basic industrial chemicals in the United States.

CMA and its member companies share the Subcommittee's commitment to reducing the incidence of occupational disease and to providing workers with safe and healthful workplaces. The record of the chemical industry in workplace health and safety is an outstanding one. Our member companies are pioneers in establishing comprehensive programs to communicate hazard information to their workers and to help workers protect themselves from chemicals in the workplace. Many of CMA's member companies also have major on-going programs in toxicology, epidemiology, and medical surveillance. CMA and its members have supported

effective regulation by OSHA, most notably the landmark hazard communication standard that recently went into effect.

S.2050 would create a new government-operated hazard notification system above and beyond existing regulatory and industry efforts. The core provisions of the bill would establish a new system whereby the Secretary of Health and Human Services would identify groups of workers deemed to be "at risk" of diseases associated with occupational exposures, would notify each individual worker within such "at risk" groups, and would provide counseling information related to the risk. The key "trigger" for identification and notification of groups of workers would be a finding that a particular employee population exposed to a hazardous substance has a rate of disease 30% greater than a comparable unexposed population. The bill also contains provisions for research, training and education activities related to medical monitoring of exposed employees.

We fully share and endorse the goal that underlies S.2050 -- to identify and notify employees of workplace hazards. But the approach embodied in S.2050 to achieve this goal, CMA believes, is fundamentally flawed. As we discuss in greater detail below, S.2050 --

- is based on inaccurate perceptions of the scope of the occupational disease problem and the efficacy of medical monitoring and surveillance;

- ignores existing statutory and regulatory provisions -- particularly those in OSHA's new Hazard Communication Standard -- that provide a sounder framework for providing hazard information to employees; and

- contains an arbitrary, unscientific trigger mechanism that will not accurately identify workers who are actually at risk of occupational diseases.

I. S.2050 RESTS ON INACCURATE PERCEPTIONS OF THE OCCUPATIONAL DISEASE PROBLEM AND OF THE EFFICACY OF TESTING AND SURVEILLANCE.

CMA in no way wishes to minimize the problem of occupationally-related diseases. There can be no question that workplace exposure to certain chemicals and other hazardous substances at unsafe levels, sometimes over a long period of time, can lead to the development of serious diseases. Both OSHA and industry have made major efforts since the enactment of the Occupational Safety and Health Act to address this problem, both by lowering exposure levels and by providing information to workers about risks and protective measures. But it is important to keep the problem of occupational disease in perspective. Some of the findings in Section 2 of S.2050 appear to reflect the notion that gained some currency several years ago that there is an "epidemic" of occupational disease in the United States, and that a significant portion of cancer cases are

occupationally-related. Almost all experts now agree that the earlier estimates were mistaken, and were based on faulty methodology. The landmark study by Professors Doll and Peto, commissioned by the Office of Technology Assessment, demonstrated that earlier estimates were much too high, and concluded that only approximately 4% of cancer cases in the United States are work-related.[1/] While occupational causes of cancer and other diseases must certainly be reckoned with, they pale in comparison to such other factors as smoking, diet, and alcohol as contributors to the nation's health problems.

Moreover, the limitations of medical testing and surveillance in dealing with the occupational disease problem must also be recognized. Testing and surveillance can be effective in helping to prevent or treat some specific diseases; but in the case of many others, intervention cannot provide workers with any meaningful protection. Where a worker has been exposed to high levels of a carcinogen in the past and is therefore at an increased risk of contracting cancer, health surveillance, after the exposure has occurred, often cannot affect the outcome in any significant way.[2/] CMA supports research designed to improve

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1/ Doll & Peto, The Causes of Cancer: Quantitative Estimates of Avoidable Risks of Cancer in the United States Today, 66 J. Nat'l Cancer Inst. 1191, 1245 (June 1981).

2/ In the case of mesothelioma, for example, treatment is ineffective regardless of when the disease is first detected.

[Footnote continued next page]

health surveillance techniques. But the limitations inherent in testing and surveillance must be borne in mind.

II. EXISTING AUTHORITIES AND REGULATIONS ARE ADEQUATE TO DEAL WITH THE PROBLEM.

The burden of establishing the need for new legislation should be with the proponents of new legislation. We submit that the proponents of S.2050 have not established, and cannot establish, such a need. S.2050 ignores the significant authority that OSHA and NIOSH already possess under the Occupational Safety and Health Act, and the major steps that have already been taken in implementing those statutory authorities to assure notification of workers at risk of occupational diseases.

Section 20(a)(6) of the OSH Act gives NIOSH the specific responsibility to investigate whether particular workplaces present hazardous conditions, and to inform affected employees of its determinations. The regulations implementing Section 20 authorize NIOSH to "conduct medical examinations, anthropometric measurements, and functional tests of employees," either on its

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[Footnote continued from preceding page]

The treatment for, and outcome in, leukemia are the same regardless of when the disease is first detected. In the case of lung cancer, the improvement in survival from early detection is so low that the American Cancer Society has rescinded its previous recommendation for periodic chest x-rays. Those types of cancers for which early detection has proved most helpful -- such as cancer of the breast, colon, rectum, and cervix -- are rarely associated with occupational exposures.

own initiative or at the request of employees. 42 C.F.R. § 85.5(a). NIOSH has extensive additional research and investigation authority under other provisions of Section 20, including the authority to require monitoring of exposures and to conduct medical examinations and tests. OSH Act § 20(a)(5). Under Section 20(d), NIOSH must distribute the results of any such monitoring and testing to employees.

More significantly, OSHA has recently promulgated a generic hazard communication standard which imposes extensive obligations on all chemical manufacturers and importers, and on all employers in the manufacturing sector, to communicate information on workplace hazards to employees -- including the risk of occupationally-related diseases. Specifically, the hazard communication standard requires chemical manufacturers and importers to identify hazardous substances that they produce or distribute, on the basis of the best available scientific data, and to develop material safety data sheets (MSDSs) that include comprehensive information on the nature of hazards presented and on protective steps against those hazards. Employers must make these MSDSs and a list of hazardous chemicals available to their employees, must label containers of hazardous substances with appropriate warnings, and must implement training and education programs to inform their workers about the hazards to which they may be exposed.

The key provisions of the hazard communication standard -- requiring chemical manufacturers to conduct hazard evaluations and include MSDSs and hazard labels in shipments to their customers -- went into effect last November. The remaining provisions of the standard, requiring all employers in the manufacturing sector to implement their hazard communication programs (including MSDSs, labeling and training), become effective later this month. Finally, OSHA has initiated rulemaking proceedings with a view toward expansion of the hazard communication standard to cover employers outside the manufacturing sector.

The hazard communication standard is supplemented by OSHA's employee exposure and medical records access rule, which requires all employers to make available to any employee or designated representative all exposure and medical records. Employers must retain such records for at least 30 years.

OSHA has also promulgated specific standards for substances such as cotton dust, acrylonitrile, asbestos, lead and ethylene oxide. Rulemaking proceedings now pending would add standards for benzene and formaldehyde. These standards have specific labeling provisions related to occupational disease risks, and include provisions for surveillance, monitoring, and testing. OSHA and NIOSH have access to MSDSs, lists of hazardous chemicals, and exposure and medical records under the hazard communication standard and the records access rule, and can use this

information to develop additional health standards, including surveillance and testing requirements.

With this elaborate federal regulatory apparatus already in place, and particularly in view of the hazard communication standard now being implemented, this is not the time to superimpose an additional hazard communication and surveillance scheme. Existing authorities are extensive, and they should be given an opportunity to work. The hazard communication standard in particular will result in the flow of extensive additional information to workers. Its requirement that employers institute and maintain a comprehensive hazard communication program will lead even more employers to adopt effective overall occupational health programs for their employees, including medical surveillance and testing. These authorities should be given enough time to address the problem, for they are likely to confirm that still another costly and burdensome regulatory scheme is unnecessary.

III. THE TRIGGER MECHANISM IN S.2050 IS ARBITRARY AND UNSCIENTIFIC.

Section 3(6) of S.2050 defines "population at risk" as "an employee population exposed to hazardous occupational exposures within which an associated disease occurs at a rate greater than a comparable population not exposed to the hazardous occupational exposure." This simplistic approach, we submit, is flawed and unworkable, and will inevitably lead to serious mistakes in classifying workers as being "at risk."

Epidemiology is an enormously useful tool in understanding risks, and in testing cause-and-effect hypotheses. But it alone cannot provide the simple, hard-and-fast answers that S.2050 suggests.[3/] Arbitrary and inflexible numerical trigger points are unworkable and unreliable mechanisms for decision-making.

The problems with the 30% trigger definition are numerous:

An "associated disease" -- one whose over-incidence triggers an "at risk" finding -- is not specifically defined in S.2050 as necessarily the result of any workplace hazard. Many other factors are known to contribute to the incidence of diseases among workers, including smoking, diet, consumption of alcohol, and local natural environmental phenomena. For some diseases, the confounding factors may not yet have been

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3/ The Henle-Koch-Evans postulates, which have been widely accepted in the scientific community (see, e.g., the 1982 Surgeon General's Report on Smoking and Health), set forth no fewer than ten criteria that need to be met before one can readily ascribe cause to a particular agent. A simple measure of over-incidence among persons exposed to the agent addresses only one of the ten criteria. Among the others, for example, are the establishment of statistical significance, discussed below; a finding of the inverse relationship (i.e., that exposure to the agent is more frequent among persons with the disease than without, holding all other risk factors constant); the presence of certain quantitative correlations over time between exposure and disease; correlations between exposure and responses in the affected individuals; and a decrease in incidence of the disease when the agent is removed. It is clear that a numerical trigger point, taken along, cannot begin to satisfy these criteria.

determined. Unless these factors can be ruled out, however, there is no basis for associating any particular incidence of any disease with a workplace hazard. Because the trigger prescribed in S.2050 fails to recognize the influence of confounding factors, is is likely to produce erroneous findings. This can lead to harmful consequences, both in terms of needlessly alarming workers and in terms of misallocation of resources.

Moreover, many hazard-induced diseases show a relatively long latency period between exposure and onset of illness. To select groups of workers as being at risk solely on the basis of present-day incidence data raises the possibility that populations will be identified on the basis of hazards which have long since been corrected. Conversely, employees exposed to a relatively new and more dangerous hazard would go unidentified under S.2050 until the latency period had run its course and morbidity figures had climbed past the trigger points.

S.2050 fails to provide any specification of the pool of workers to be assessed for a 30% over-incidence of disease. It is unclear whether that pool is to consist, for example, of all employees nationwide exposed to a class of agents thought to contribute to a particular disease, or of all workers exposed to a particular agent, or those in a particular industry, or working for a particular employer, or in a particular plant, or even at a particular site within the plant. This administrative choice can

greatly skew the results of any study, and hence will profoundly affect both employers' responsibilities and the measures taken to protect workers' safety under the bill. Note further that even workers who share identical industrial classifications and job categories may in fact work in totally different environments, so far as exposures are concerned.

It is a matter of elementary statistics that a small sample of workers is more likely than a larger number to show, purely by chance, an untoward percentage of any measurable event -- including the incidence of disease. In a properly-designed study, this chance factor can be quantified through the calculation of levels of significance. S.2050, however, neither calls for the gathering of data in a scientifically responsible way nor specifies any appropriate level of significance.

The use of industry-wide populations for analysis might help to reduce the factor of chance, by making the samples larger, but at the same time would raise other problems. With the increased number of worker populations, the problem of dealing with confounding factors, discussed above, is compounded. Moreover, if worker populations are analyzed on an industry-wide basis, an employer that maintains an extremely safe workplace might find its own workers characterized as being at risk merely because its competitors are less vigilant.

S.2050 similarly fails to specify the "comparable population" against which the exposed population is to be measured -- another choice that will directly affect which workers are identified as being at risk. Moreover, there is no requirement that the studies or surveys leading to a determination of risk meet any criteria for scientific soundness, not even the most elementary standard of peer review.

In the last analysis, disease causation is much too complex a scientific question to be reduced to a simplistic formula such as that contained in S.2050.

IV. ADDITIONAL COMMENTS ON SPECIFIC PROVISIONS OF S.2050.

Section 2: As already noted, the findings reflect an unfounded certainty regarding the scope of the occupational disease problem. While there is no question that problems still exist, there is no clear consensus that "a significant number of identifiable occupational populations" are at risk of developing diseases from hazardous occupational exposures, or that such exposures "constitute a substantial burden on interstate commerce." Nor is it clear that it is "often" (rather than "sometimes") possible to intervene effectively to prevent or treat disease during the period between exposure and onset.

Section 4: It is essential that the Risk Assessment Board have available to it the best possible expertise, from

whatever source. We believe it unduly restrictive to limit membership on the Board to career or commissioned Public Health Service officers. Outside experts -- from industry, labor or the academic world -- should be eligible for appointment to the Board, and additional ways should be found for the Board to tap outside expertise.

S.2050 represents some improvement over H.R.1309 in that it provides notice and an opportunity for interested parties to comment on the proposed findings and recommendations of the Board. But so long as the 30% trigger mechanism or any other arbitrary trigger mechanism is included in the bill, the Board's decision-making process will necessarily be fatally flawed.

Section 5: For the reasons stated above, CMA believes that the system of government notification of individual workers should not be superimposed on the existing system of employer notification embodied in the hazard communication standard.

The addition of a provision for judicial review of the Secretary's determinations is a welcome improvement over H.R.1309. But the scope of review set forth in Section 5(i)(2) is too limited; the Secretary's determination should also be required to be supported in the rulemaking record.

Sections 6-7: CMA supports further research on the efficacy of medical monitoring and surveillance. Section 20 of

the OSH Act already provides NIOSH with extensive research, demonstration, and experiment authority. We frankly question whether the establishment of a new network of occupational and environmental health centers for education, training, and technical assistance is necessary. And we are concerned that some of the functions envisioned by Sections 6 and 7 would be counterproductive, since they would duplicate or supplant effective employer occupational health programs.

Section 8: CMA supports the principle of nondiscrimination against employees who have been identified as being at risk of occupational diseases. Questions of benefit retention in medical transfers, however, are complicated and are best left to the employer-employee bargaining process.

Section 9: It is difficult to quarrel with the notion that health care financing systems should provide for appropriate medical testing, evaluation, and monitoring. But in light of the limitations of medical monitoring and surveillance, a much better notion of the cost and efficacy of such systems needs to be developed before such coverage is mandated.

CONCLUSION

CMA agrees that we need to continue to find ways to strengthen existing systems for informing workers of significant health risks in the workplace. S.2050, however, does not provide a sound approach for doing so. It ignores existing regulatory authorities -- particularly OSHA's hazard communication standard. And its central mechanism -- the 30 percent trigger -- is scientifically unsound and will lead to misidentification of workers at risk.

STATEMENT OF THE AMERICAN FARM BUREAU FEDERATION
TO THE LABOR SUBCOMMITTEE
OF THE SENATE COMMITTEE ON LABOR AND HUMAN RESOURCES
REGARDING S. 2050 -- THE HIGH RISK OCCUPATIONAL DISEASE NOTIFICATION
AND PREVENTION ACT OF 1986

June 3, 1986

The American Farm Bureau Federation is the nation's largest general farm organization, with a current membership of 3.3 million families in 49 states and Puerto Rico, including three-fourths of the commercial farms and ranches in this country. Farm Bureau is a voluntary, nonprofit organization, financed entirely by annual dues paid to more than 2,700 County Farm Bureaus.

Some 750,000 farmers and ranchers are employers who would be affected by the enactment of S. 2050.

At a time when every effort needs to be made to reduce the federal deficit by cutting expenditures, we oppose legislation such as S. 2050 that would create a new and duplicative federal program. It is our view that the federal government has already intervened in many areas of activity and responsibility that should have been left to state and local government or to the private sector. It would be irresponsible for the Congress to embark upon a new program in the area of occupational health that, within a short period of time, would likely balloon into a very costly entitlement program.

While it may be true that additional attention needs to be given to the prevention, detection and treatment of occupationally-induced diseases, we do not agree that a new federal agency is needed to accomplish that goal. In our view, the Occupational Safety and Health Administration of the Department of Labor has been given ample authority and has the needed expertise to carry out that responsibility. We are not aware of any expertise within the Department of Health and Human Services in the areas of occupational disease, and it would be unnecessarily duplicative to establish an additional program in the Department.

In addition to our concern about the unnecessary duplication and cost of the proposed new program, we believe the broad and arbitrary definition of "population at risk" contained in Section 3 of the bill would lead to widespread alarm and fears among employees and an explosion of liability claims against agricultural and other employers, without any scientific basis for such action.

A finding by the Risk Assessment Board, which would be created by this bill, that every person employed in a particular occupation is "at risk" because of a 30 percent higher incidence of a disease as compared to the general population is overly simplistic and could not provide any reliable information regarding the magnitude of the risk for each person so employed. Worksite conditions and term of employment vary widely, and many factors may well have a bearing.

S. 2050 defines "hazardous occupational exposure" to mean "any harmful chemical, physical or biological agent; industrial or

commercial process or activity found in the workplace which is associated with the risk of disease, or...any occupation which is associated with the risk of disease."

It is difficult to imagine how that definition could be written in broader terms. We are concerned about the effect the procedures and requirements of this bill would have on the cost of workers' compensation programs in the various states. There is no requirement that the disease be one arising out of and in the course of employment; yet the bill provides that the cost of medical monitoring and treatment by insurance carriers can be the basis of a valid subrogation claim against a workers' compensation program.

Without doubt, the finding by an official agency of the federal government that those who work in a particular occupation are members of a "population at risk" would carry considerable weight in compensation proceedings and/or third-party liability litigation, possibly even before the disease is apparent.

The implications of this legislation in the area of agricultural employment are frightening. Agriculture employs large numbers of temporary or seasonal workers, who work at any one worksite or for any one employer for short periods of time. Documentation on these workers is at best skimpy. Many of them have several Social Security numbers, all issued under different names. Perhaps 15 percent are undocumented foreign workers. It is literally impossible for an agricultural employer to maintain any kind of credible list of such employees over an extended period of time. Such an employer would have no way to communicate with a great many persons previously employed.

The Occupational Safety and Health Adminstration, as a part of its study of the need to require agricultural employers to provide sanitation facilities for agricultural workers employed as hand laborers in fields, has determined, based on expert opinion, that farmworkers have much higher incidences of certain parasitic diseases than is true for the general population in this country. That agency has failed to show that such higher incidences are the direct result of the lack of sanitation facilities in fields or to other conditions at the place of work. Many of these workers come from severe proverty environments in this, and other countries, and it is likely that the higher incidence of such diseases arises out of conditions at the place of residence.

If this bill is enacted, it will cause many employers to cease providing health insurance coverage to their employees, since the bill would lead to widespread and costly medical monitoring and testing, causing an escalation in the cost of such coverage.

We urge the Committee to reject enactment of S. 2050. If the Committee determines that additional attention needs to be given to prevention and early detection of occupationally-induced diseases, it should instruct existing agencies, such as the Occupational Safety and Health Administration, to develop or expand such a program. Enactment of this bill would create a very costly new federal program and further aggravate an already disastrous liability insurance situation.

We ask that this statement be made a part of the hearing record.

BEFORE THE UNITED STATES SENATE COMMITTEE
ON
LABOR AND HUMAN RESOURCES
SUBCOMMITTEE ON LABOR

COMMENTS ON S. 2050
THE HIGH RISK OCCUPATIONAL DISEASE NOTIFICATION AND PREVENTION ACT OF 1986

Submitted by:

The American Association of
Occupational Health Nurses
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Date: May 29, 1986

While AAOHN supports the concept of a federal high risk occupational disease notification and prevention law, we have grave concerns about the proposed bill (S. 2050).

Role of the Occupational Health Nurse

We strongly object to the lack of recognition of occupational health nurses in the proposed bill. One of the stated purposes of the bill is to:

> authorize and direct the certification of occupational and environmental health facilities which have a primary purpose of educating and training physicians and social service professionals in local communities throughout the United States. (Section 2-b-2)

This statement reflects a misconception of how occupational health services are delivered in a majority of American workplaces.

The responsibility for occupational health services rests rarely (if at all) with social service professionals and only occasionally with physicians. Occupational health nurses have primary responsibility for occupational health services at most of the nation's workplaces.

A joint research project conducted recently by AAOHN and the Schering Corporation provides a profile of the current practice of occupational health nursing:

-- In most instances, occupational health nurses are the only onsite health professionals. Fifty-two percent of AAOHN members practice without onsite physicians.

-- In most instances, occupational health nurses have management responsibilities for occupational health programs. Seventy-six percent of AAOHN members report that they participate in management decision-making.

-- In most instances, occupational health nurses routinely conduct health surveillance of employees at risk. Fifty-six percent of AAOHN members report that they are responsible for health surveillance as required by OSHA standards.

Occupational health nurses can provide leadership to implement the most important elements of the bill. In fact, many companies already have nurse-managed programs that can be used to provide the kind of notification described in the bill.

Counseling

Although the bill refers to the importance of counseling employees at risk, it fails to take advantage of the significant experience that occupational health nurses have in counseling workers regarding health or safety problems. The occupational health nurse usually is the first contact that an identified worker has with a health professional. The one-to-one act of counseling is a major component of the occupational health nursing practice.

Occupational health nurses are the most appropriate professionals to handle sensitive issues between employers and employees concerning notification and counseling requirements described in the bill.

Occupational health nurses can interpret potentially disturbing notifications for workers and counsel them in these situations.

Occupational health nurses can facilitate workers' understanding by explaining the nature of exposures, what the exposures are, and resulting problems, including how long health problems will take to develop.

Not only can occupational health nurses provide this information, they can provide it in an environment that is supportive of the individual, allowing expression of feelings and allaying anxiety as workers receive information expressed with understanding and compassion.

Equally important, occupational health nurses can provide referral and follow-up to prevent workers from becoming lost in a complex and perplexing system.

Occupational health nurses can ensure that workers retain the right to make informed choices under the law.

Risk Assessment Board

AAOHN applauds the authors of the bill for including an occupational health nurse as one of five members on the Risk Assessment Board. However, the same rationale which supports the addition of an occupational health nurse to the Board, supports the meaningful involvement of these skilled health professionals in other aspects of the notification and prevention functions.

AAOHN also strongly recommends that membership on the Risk Assessment Board include a combination of Public Health Service employees and qualified individuals from the private sector.

We further recommend that the Risk Assessment Board assume responsibility for deciding what criteria should be used to identify populations at risk.

Health Monitoring and Surveillance

We suggest that the bill's continual references to "medical" in connection with monitoring and surveillance be changed to "health." The current wording gives the impression that these important activities are performed exclusively by physicians.

Approximately 56 percent of practicing occupational health nurses are responsible for "medical" surveillance as required by OSHA standards as a primary function of their practice.

Research and Monitoring

Although early detection and notification of illness are vital, they do not include the most significant, cost-effective component of prevention--primary prevention.

Funds in this bill should be directed toward comprehensive research of substances and processes before they are introduced into the workplace.

Funding for primary prevention would contribute significant dollar savings in treatment and monitoring of health problems, as well as in eliminating unnecessary suffering of workers and their families.

In addition, primary prevention requires comprehensive education funding for workers and the public concerning protective mechanisms and safety controls.

Ongoing education should be provided for health care workers to maintain up-to-date knowledge and expertise. Educational funding should be channeled through undergraduate and graduate college and university programs, as well as continuing education efforts.

While this bill provides for some professional training through occupational and environmental health centers, more emphasis should be placed on the primary prevention components of training and information programs.

In addition, only physicians and social service workers have been identified as training recipients; occupational health nurses, key members of the health care team, should be included as recipients of these training efforts.

Cost Issues

AAOHN supports the concept of providing services such as research resources, diagnosis, treatment, health monitoring and programs for families through occupational and environmental health centers.

However, we have grave concerns about the funding required to support qualified personnel and to purchase necessary equipment.

In addition, we have serious doubts about the availability of adequate funding sources for meaningful notification and follow-up for identified workers at risk.

Conclusion

We wish to reiterate our support for a bill of this type. However, we strongly urge that occupational health nurses be included in the key functions of the bill.

AAOHN and the Occupational Health Nursing Profession

The American Association of Occupational Health Nurses is the professional association for registered nurses who provide on-the-job health care for the nation's workers.

The Association serves as an advocate for the profession, establishes standards of practice, supports certification and assists the occupational health nurse in providing quality health care.

Occupational health nursing is the application of nursing principles to help workers achieve and maintain the highest level of health throughout their lives.

This specialized practice is devoted to health promotion at the workplace based on prevention of illness and injury.

One of the goals of the occupational health nursing practice is to achieve corporate cost effectiveness by promoting wellness within the work force. The occupational health nurse is the key to the delivery of comprehensive occupational health services.

003.014

Statement of

Associated General Contractors of America

Submitted to the

Subcommittee on Labor of the

Senate Labor and Human Resources Committee

On

S.2050 - The High Risk Occupational Disease

Notification and Prevention Act of 1986

May 22, 1986

AGC is:

- More than 32,500 firms including 8,400 of America's leading general contracting firms responsible for the employment of 3,400,000 plus employees;
- 108 chapters nationwide;
- More than 80 percent of America's contract construction of commercial buildings, highways, industrial, and municipal - utility facilities;

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The Associated General Contractors of America (AGC) appreciates the opportunity to express its views regarding S.2050, the "High Risk Occupational Disease Notification and Prevention Act of 1986." AGC shares the Committee's objective of establishing a safe and healthy working environment for our nation's workers. However, S.2050 is completely inappropriate for the construction industry and the construction industry should be excluded from its coverage. Because of the failure to exclude the construction industry, AGC opposes passage of S 2050.

S.2050 - The High Risk Occupational Disease Notification and Prevention Act of 1986 would mandate research and surveillance of employee exposure to health hazards, establish procedures to identify worker populations at risk and provide for employee notification and counseling, health facilities, and enforcement authorities, including provisions for employee discrimination complaints.

Existing Construction Industry Standards

AGC believes that many of the provisions of the bill are unnecessary because they duplicate existing statutes or regulatory standards.

The potential, yet limited risk of construction employee exposure to hazardous substances, has already been appropriately identified and addressed by the Occupational Safety and Health Administration (OSHA). The Occupational Safety and Health Standards for the construction industry (29 CFR Part 1926) directs the employer in the proper training and handling of hazardous materials. Specifically, 1926.21(b)(2) (Safety Training and Education) states, "The employer shall instruct each employee in the recognition and avoidance of unsafe conditions and the regulation applicable to his work environment to control or eliminate any hazards or other work exposure to illnesses." In addition, the Occupational Safety and Health Act already requires employers to notify employees regarding hazardous substance exposure and to retain all pertinent medical records for a period of 30 years.

Additionally, the Occupational Safety and Health Administration (OSHA) is currently considering an Advisory Committee on Construction Safety and Health recommendation to promulgate additional, yet separate, Hazard Communication Standards for the construction industry.

Limited Nature of Construction Employee Exposure

AGC believes that any regulation or legislation on hazard notification must consider the low incidence rates of occupational illnesses for construction. Based upon the Bureau of Labor

Statistics data, occupational illnesses in construction are almost exclusively associated with repeated trauma (noise-induced hearing loss and other conditions due to repeated motion, pressure, or vibration) and account for 3 of every 5 recorded illnesses.

The typical construction employee rarely experiences extended or concentrated exposure to hazardous materials. Where such infrequent exposure may occur, any new standard or legislation should be limited specifically to those situations.

In light of these statistics, AGC urges that any hazard communication standards or legislation 1) recognize the limited nature of construction employee exposure, 2) recognize the limited types of construction operations where exposure to hazardous substances may occur, and 3) recognize that the construction industry is composed of thousands of small highly competitive businesses.

Specific Provisions of S.2050

Under S.2050, employee notification would be determined by placing any employee exposed to any potentially hazardous substance in a category of risk in which disease occurs at a rate 30 percent greater than a comparable population not exposed to a particular substance. AGC believes that this approach to classification is inappropriate because employees having even a minimal or incidental exposure would automatically be placed in a risk category. In essence, S.2050 assumes no differentiation in the degree of risk exposure. Additionally, the Bill's classification process has the potential to create unfounded claims, employee uncertainties and increased liability and insurance costs which will prove burdensome for small highly competitive construction contractors.

Section 8 of S.2050 - Employee discrimination provides that no employer, insurance carrier, or other person shall discharge or in any manner discriminate against any employee on the basis that the employee is or has been a member of a population that has been determined by the Secretary to be at risk of disease. This section would create serious problems for employers of a person who, during employment under a prior employer, was subjected to an exposure which subsequently resulted in a risk classification. The current employer would clearly be in a Catch 22 situation.

Section 9 of the Bill provides for injunctive relief, allocation of costs for health care financing, and subrogation. This section would require that any health care insurance system cover the cost of medical monitoring and treatment triggered by the notification. In the case of contract construction this would constitute an insurance subrogation claim against a workers compensation

program or insurance carrier. Ultimately, states will be forced to pay more benefits and the cost of workers compensation programs will rise, causing construction costs to increase as a result.

AGC appreciates the opportunity to comment on S.2050 and urges the Subcommittee to consider the ramifications of the bill on the highly competitive decentralized construction industry, an industry of thousands of small firms with high labor turnover and an industry whose exposure to high risk occupational disease cannot be equated to, or addressed by, standards applicable to hazardous substance manufacturing.

AGC believes in the maintenance of a safe and healthful work environment for all employees. AGC does not believe that S.2050, "The High Risk Occupational Disease Notification and Prevention Act of 1986," represents a step in that direction in the construction industry. AGC opposes enactment of S.2050 because it fails to exclude the construction industry from coverage.

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AMERICAN LUNG ASSOCIATION
The Christmas Seal People ®

May 13, 1986

The Honorable Don Nickles
Chairman
Subcommittee on Labor
Senate Labor and Human Resources Committee
SH-608 Hart Senate Office Building
Washington, DC 20510

Dear Mr. Chairman:

The American Lung Association would like to submit, for the hearing record, the attached statement on S. 2050, "Identification and Notification of Workers." The ALA is in full support of the need to develop mechanisms to identify groups of workers at high risk as a result of occupational exposures and to notify them regarding the specific risks they may face as a result of exposure.

Meeting the laudable objectives of S. 2050 will mean facing severe limitations in the available data base upon which to make risk decisions and in professional resources. These deficiencies can be overcome by strengthening the support of relevant biomedical research and training. ALA would hope the Subcommittee addresses this concern in future hearings.

Sincerely,

Alfred Munzer

Alfred Munzer, MD
Chairman
American Lung Association
American Thoracic Society
Government Relations
Committee

AM:tsd

enclosure

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AMERICAN LUNG ASSOCIATION
The Christmas Seal People ®

STATEMENT OF

THE AMERICAN LUNG ASSOCIATION and

THE AMERICAN THORACIC SOCIETY

to the

SUBCOMMITTEE ON LABOR

COMMITTEE ON LABOR AND HUMAN RESOURCES

UNITED STATES SENATE

RE: S. 2050 - IDENTIFICATION AND NOTIFICATION OF WORKERS

MAY 15, 1986

The American Lung Association and its medical section, the American Thoracic Society, appreciate this opportunity to comment on S. 2050, "Identification and Notification of Workers."

The protection of respiratory health is of primary importance to the ALA. Founded in 1904 to fight what was then the country's leading cause of death, the ALA's current goal encompasses the control and prevention of all lung diseases. A major program emphasis is the control of air pollutants in outdoor, indoor, and workplace environments. On May 9, 1986, the ALA announced a major new occupational health program - "Future Workers Education Project." The objective of this program is to educate young people about the variety of workplace hazards before they enter the job force. Unfortunately, for many workers, education about respiratory hazards in the workplace will be too late.

There can be no doubt that workers and others in our society benefit from the accurate and dispassionate characterization of the particular risks that each face, and the dissemination of information regarding these risks. The often inadequate communication between those who generate and interpret risk assessment data, those who are responsible for public policy decision-making, and those who must consider whether to assume these risks has at times been responsible for temporary setbacks in enhancing the accurate perception of risks in the workplace. Freer dialogue between workers, management, government, and academia will move us closer to the goal of effective communication about risks and rational choices to reduce them.

There are problems in achieving the desired objective. The scientific data base on occupational risks, while at times substantial but underutilized, will often be found to be incomplete, or worse, virtually absent. The nature of the hazard may be poorly understood, or perceptions of it distorted. In prevention of disease, occupational or otherwise, we must focus on effects which impair bodily function or reduce longevity. All risks are not the same. For example, asbestos-related pleural plaques (a benign marker of exposure) and lung cancer do not deserve equal attention. In addition, the concept of dose relatedness of most occupational risks must be understood and accepted; that is, risk varies by the level and duration of exposure required to cause the effects.

The statistical methods of expressing elevated risk may be difficult to understand. They can, however, provide substantial assistance in understanding the potential hazard. Risk can be stated as a multiple of an "expected" incidence in the general population which is unexposed to the hazard, but comparable in every other way, including the personal life style and other factors which may influence the risk of the disease of interest. There are insufficient data which provide information on the influence of such confounders on occupational risks. Increasing scientific investigation which is focused on this important area of public health, and a willingness to use the resultant information in a balanced manner, are needed.

How, then, can we best identify and notify workers who are at increased risk of developing disease? Critical to the accomplishment of this objective is the enlargement of a high quality scientific data base which relates adverse health effects to qualitative and quantitative aspects of exposure, taking into account potential host and other factors which may modify the outcome.

The extent of our research efforts in this important area of public health is regrettably inadequate. Important contributions have come from many biomedical disciplines, extending well beyond the traditional public health community. Physician-investigators, dust physicists, environmental chemists, immunologists, bioengineers, cell and molecular biologists, biochemists, physiologists, epidemiologists, and statisticians should be encouraged to work collaboratively to increase our fund of knowledge regarding the determinants of occupational disease. This type of broad-based research is the only reliable path to the prevention of these diseases.

The basis for rational and effective risk notification and management is two-fold. First, the level of excess risk which triggers the process must be determined. This threshold risk level is a social policy issue and may appropriately be promulgated through legislative guidelines. Concern over true risks of 30 percent above the expected rates in the absence of the occupational exposure as specified in S. 2050, is appropriate.

The second consideration is, however, both more complex and less easily precisely articulated. The determination of a particular occupational risk requires careful evaluation of the extent and quality of the science supporting it. Particularly in the case of long exposure, long latency diseases, judgements must be made regarding whether workplace exposures are associated with, or caused the disease. This type of analysis provides critical information. Importantly, it reveals the level of uncertainty or certainty that an elevated risk is not due to chance. If predetermined elevations of risk are to trigger a process of identification and notification which may be individually and generally disruptive, and consumptive of limited resources, scientific studies must be examined for level of confidence that an observed

risk is, indeed, elevated. Statistics cannot, however, tell us if such a risk estimate is the result of the workplace exposure or a confounder such as smoking. Thus, the selection of a valid comparison population is critical. These are only some of the methodological issues which must be considered in coming to a conclusion regarding the presence and extent of occupational risks.

The framers of S. 2050 recognize that this second function, of carefully weighing the scientific evidence, requires special expertise and is likely to be as dynamic as the science being evaluated. Establishing a national risk assessment board is a reasonable approach. The credibility of such a panel depends on a number of factors. It must be comprised of respected scientists who are experienced in these issues. The panel, through its composition, must, in both fact and perception, be balanced in its perspective. Board members should represent the range of disciplines engaged in occupational disease research and treatment. In this regard, we would suggest an expansion of the size of the board in order to include other disciplines, such as immunologists and statisticians. Further, we would suggest the inclusion of non-governmental scientists to assist in achieving the needed stature of the board.

We would like to offer these additional comments on S. 2050:

- o Section 5, Employee Notification and Counseling: The burden of notification should be placed on the individual employers with a mechanism requiring the development of a notification plan submitted to and approved by NIOSH. This will facilitate interaction with the health and safety staff of the employer and address concerns related to previously employed workers. We believe that requiring the employer to accept responsibility for notification of employees will

also serve to simplify the system of notification and limit the expense of implementing such a notification program.

The contents of the notification should also include information on the applicable OSHA standard and the compliance record of the employer which relates exposure data of specific employee populations.

We would also suggest a role be considered for NIOSH related to the dissemination of information. NIOSH is the initial point for development of this information and its expertise should be utilized in prepared worker information.

- o Section 6, Occupational and Environmental Health Centers: This section specifies the selection of centers from existing NIOSH ERC's and NIEHS centers. We would suggest that an open competition be considered in order to select other such centers within academic institutions which meet these criteria. An example would be the Specialized Centers of Research Program under the National Heart, Lung and Blood Institute on occupational diseases.

The program for identification and notification of workers at risk of developing serious illness as a result of workplace exposures provided in S. 2050 expands the legislative and regulatory tools available to prevent and control occupational diseases. The program builds on the many established programs, such as hazard communication, and introduces important new concepts for the control of occupational diseases. This program becomes the logical next step to hazard communication providing information on risks and notifying workers when medical surveillance is indicated.

STATEMENT

OF THE

BLUE CROSS AND BLUE SHIELD ASSOCIATION

ON

S. 2050

"The High Risk Occupational Disease Notification and Prevention Act"

To The

Subcommittee on Labor

Committee on Labor and Human Resources

United States Senate

May 15, 1986

The Blue Cross and Blue Shield Association is the national coordinating agency for the nation's Blue Cross and Blue Shield Plans. Our Plans currently provide prepaid health benefits to over 78 million Americans. We appreciate the subcommittee's invitation to us to comment on S. 2050, "The High Risk Occupational Disease Notification and Prevention Act."

We share the belief, expressed in Section 2 of the bill, that workers have a fundamental right to know they have been exposed to an occupational hazard and are at risk of contracting an occupational disease. And, we agree that medically appropriate monitoring, cost effective preventive care, and early detection and treatment programs could do much to minimize the human suffering and high costs associated with diseases caused by hazardous occupational exposures. The challenge is to find a fair, appropriate, and politically acceptable means of paying for those worthwhile activities, given that they will generate substantial costs.

The approach taken by S. 2050 is to make the occupational disease related monitoring, preventive care and treatment of certain persons designated as at-risk by the federal government a mandated benefit to be provided by health care financing systems, which are defined to include public and private health insurance programs, Medicare, Medicaid and the Social Security Disability programs.

Our comments are limited to those sections of S. 2050 which would affect us as health care prepayment organizations, specifically, those sections which appear to mandate that private sector health insurers provide certain special benefits to notified employees, prohibit discrimination against notified employees by private insurers and provide for subrogation by health benefits payers against workers' compensation programs.

MANDATED BENEFITS

Section 9(c) of the bill states; "The cost of testing, evaluation and medical monitoring required by an employee as a result of a hazardous occupational exposure and subsequent notification by the Secretary that such employee is in a population at risk....shall be included as a covered item in any health care financing system available to such employee through his employment or as an optional covered item for an individual purchaser of health insurance."

The Blue Cross and Blue Shield organization firmly believes that such legislatively mandated health benefits are an inappropriate interference in the private financing of health benefits and are poor public policy.

Employee benefit plans are part of a contractual arrangement between the employer and employee. The contract is the product of discussion and negotiation between them. With respect to health benefits, we believe that the subjects for agreement should include the level and type of benefits which best fit the needs of the employees and the ability of the employer to finance them. When government mandates a

a particular type of benefit as a part of this private agreement, government inserts itself into the negotiation process and, in doing so, limits the options otherwise available to both employer and employee.

Mandated health benefits nearly always favor particular types of beneficiaries or particular providers. Tremendous pressure is already exerted by providers at the state level to mandate insurance payment for their services. Once the precedent is established by approving just one mandated benefit, the federal government will be faced, for example, with having to decide if pediatric care is preferable to drug abuse treatment. Or, you may have to vote on legislation in which podiatrists are to be favored over psychiatric social workers or acupuncturists.

S. 2050 would, in effect, require employee benefit plans to pay for the cost of testing, evaluation, medical monitoring and treatment "required by an employee" as a result of a hazardous occupational exposure without clearly allowing employers and health care financing systems to establish what would be a medically appropriate, cost effective strategy for any particular hazardous exposure. The language can be interpreted to require that health care financing systems pay for whatever services might be delivered as long as those services were related to an officially designated hazardous occupational exposure. Broad entitlements of this type generate runaway benefit costs.

In your consideration of mandating benefits for employees exposed to an occupational hazard, it is extremely important to keep in mind that employers have only so many dollars to spend for employee health benefits. In the current health benefit cost containment environment, employers required to provide special benefits for certain

employees are quite likely to reduce other areas of health benefit coverage for all employees in order to offset the added cost of the special benefit. Thus, the other employees of such an employer would lose benefits they and their employers deem desirable, in order to make new benefits available to a select group of fellow workers who have been identified by the government.

The Blue Cross and Blue Shield Association and its member Plans have raised these same concerns at the state level and all too often our fears have been realized. In many states, employers carry enormous financial burdens because of benefits mandated by the state. During the past decade, the states have enacted over 500 mandated insurance benefits and in the process have profoundly affected the cost and utility of group health insurance as a means of providing employee health benefits.

The principal result of all this state legislative activity has been higher health insurance premiums and a dramatic increase in the number of employers who now self-fund, rather than purchase underwritten insurance for their employee health benefits. By self-funding, employers are able to shelter themselves, under ERISA's preemption clause, from state benefit requirements. Today, a dozen years since ERISA was enacted, workers in approximately half the country's companies have uninsured employee health benefits a result of this disparity in regulation.

In the case of S. 2050, we understand the term "health care financing system" to include the self-funding by employers of their employees' health benefits. Because ERISA does not preempt federal regulation of employee benefit plans, H.R. 1309 would thus require both insured and

self-funded employee health benefits to provide the mandated benefits for those employees the government designates as eligible. Although a federal mandate applicable to both insured and self-funded employee benefits would not work to the competitive disadvantage of insurers, we still believe that a mandated health insurance benefit is an inappropriate way for government to deal with the particular set of health problems at which S. 2050 is aimed. Further, as a practical matter, a mandated health insurance benefit is unnecessary. If an employer is required to provide notified employees special benefits for testing, evaluation and medical monitoring, and wishes to do so through its group health insurance, the insurance carriers will either provide the desired coverage or face losing the entire group to competitors willing to do so. In short, competition will make the regulation of insured health insurance benefits redundant.

DISCRIMINATION

Section 8(a) of the bill provides that no employer, insurance carrier, or any other person shall discharge or in any manner discriminate against any employee on the basis that the employee has been notified by the Secretary of Health and Human Services that he is at risk of any occupational disease .

Section 8(c) goes on to provide that no health care financing system shall in any way discriminate against an employee, who has been notified by the Secretary that he is at risk, with respect to the payment of costs associated with a medical monitoring program or any subsequent treatment, including treatment required by a medical monitoring examination or the onset of disease.

We are concerned that this language is susceptible to very broad interpretation and is confusing because, while Section 8(a) applies to employers and insurance carriers, Section 8(c) applies to health care financing systems which include public and private health insurance programs.

It is not clear to us just what practices by health care financing systems and insurers might constitute discrimination against an employee who has been notified of exposure to an occupational hazard. For example, the language could be construed to prohibit insurance carriers from charging groups with notified employees a premium which reflects the extra risk those notified employees represent.

In addition, S. 2050 requires that the mandated coverage be provided in individual (nongroup) health insurance policies. Application of the mandate to individual policies would create an administrative nightmare for those companies still offering individual health insurance coverage, and this includes all Blue Cross and Blue Shield Plans. Our Plans, because they currently community-rate individual coverage would have to charge all individual subscribers for the mandated benefits, but only certain subscribers, designated by the federal government, would actually be eligible to receive them. Keeping track of who, among a plan's individual subscribers, was eligible would be extremely cumbersome. And, because all subscribers would share the cost, the mandated benefits could cause our premiums to become unaffordable for some.

On the other hand, if the cost of the special benefits were to be charged only to those individuals who purchased it as an optional coverage, the benefit would be more expensive then if those individuals simply purchased the testing, evaluation and monitoring services directly out-of-pocket. By mandating individual insured benefits, the government would be adding an unnecessary element of cost for these individuals who cannot obtain the benefit from their employers.

SPREADING THE COST

In studying S. 2050, we wondered whether its authors assumed that the use of health insurance to provide the mandated benefits would spread the cost more widely than would be the case if employers were simply required to provide the benefits to any of their employees who are designated as exposed to an occupational hazard. Unless the "discrimination" prohibited by the bill were so inappropriately defined as to prohibit charging a premium commensurate with the added risk that notified individuals would represent, we do not believe that would be the case. Except for small groups and those notified employees who might wish to purchase individual policies, the cost of the mandated benefits would tend to fall directly upon employers with notified workers. This would result because most larger employers either self-fund their health benefits or have experience-rated insurance coverage in which the premium they pay directly reflects their group's use of health benefits.

Small employers, however, present a special problem. In dealing with small insured groups Blue Cross and Blue Shield Plans consider them as part of a pool and calculate a small group premium based upon spreading the risk more broadly across the composite, "super group". This is done in an effort to set affordable premium rates in a part of the market where, due to small group size, changes in the health status of few groups members can have a huge impact on the financial risk a small group presents.

In small group pooling or community rated situations, which generally involve employers of 100 or fewer persons , the higher risk of health care costs presented by "notified" employees would thus be spread across a larger population. If S. 2050's mandated benefits were to create significant costs in this already difficult to insure segment of the market, competitive forces could pressure Blue Cross and Blue Shield Plans to discontinue pooling and instead rate each small group according to the risk which it alone presents. This would result from healthier small groups refusing to "subsidize" the cost of S. 2050's special benefits for persons in other small groups. If this were to happen, then the smaller the insured group the greater its premium increase would be, due to the inclusion of "notified" employees. In some cases, small employers might find health insurance altogether unaffordable. Others might simply require all employees to pay a higher share of the premium out of pocket in order to offset the added cost of mandated benefits available only to some designated fellow employees who may have been endangered by an occupational hazard.

It appears to us that S. 2050 would require a notified employee's current employer to provide the mandated benefits. In a situation where the hazardous exposure took place at the plant of a former employer rather than the employee's current one, this does not seem a fair way to deal with the current employer. It also lead to subtle forms of hiring discrimination against job seekers whose work records reveal their former employment in high risk industries.

WORKER'S COMPENSATION

Currently, workers' compensation is the primary source of payment for workers injured on the job. S. 2050 would make health care financing systems the primary source of payment for costs associated with monitoring, prevention, and treatment of disease caused by a hazardous occupational exposure and would provide for subrogation against workers compensation for costs of treatment but not costs of monitoring and prevention. Given the occupational nature of the problem with which this legislation deals, we believe that the worker's compensation system rather than the health care financing system is the more appropriate mechanism through which to finance any benefits and services related to hazardous exposure on the job. In fact, most current health insurance contracts probably exclude benefits for occupational injury, making worker's compensation the primary source of coverage.

Workers compensation coverages are related and designed to deal specifically with those workers suffering job related illness or injury, whereas health insurers provide benefits to the entire workforce and will have administrative problems segregating certain employees within an insured group and within pooled groups for purposes of providing special benefits. Using the existing workers compensation system for the entire program would save both time and expense which otherwise would be involved in having the health care financing system seek reimbursement from the worker's compensation carrier for treatment costs only.

SUMMARY

In closing, we would like to restate our concern with finding a way to deal fairly and effectively with the needs of employees who suffer hazardous occupational exposures, but also to emphasize our concern with S. 2050's approach to dealing with the problem by creating a federally mandated health insurance benefit for a select class of employees.

If employers are required to provide special health benefits to certain of their employees, there is no need to pass a federal law requiring health insurers to make such benefits available. Competition among health insurers will assure the availability of insured benefits, if employers desire them.

In the case of persons seeking to purchase optional individual coverage for the special benefits, insurance is not an economically efficient means of providing the services. Because those who purchase such insurance will almost surely use the benefit, the premium charged will simply be the full cost of the services covered, plus the insurer's administrative and overhead expense. An individual would be better off to simply purchase the health services directly out-of-pocket.

We recognize you are dealing with very difficult economic and political problems in this legislation and we would be than willing to continue this dialogue with you, employers, labor groups, and occupational safety and health experts as you consider whether S. 2050, as currently drafted, is the best way to solve those problems.

BRYN MAWR COLLEGE
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TESTIMONY OF

CAROLYN NEEDLEMAN, PH.D.

RELATED TO S. 2050,
THE HIGH RISK OCCUPATIONAL DISEASE
NOTIFICATION AND PREVENTION
ACT OF 1986

FOR THE SUBCOMMITTEE ON LABOR,
SENATE COMMITTEE ON LABOR AND HUMAN RESOURCES

MAY 15, 1986

Chairman Nickles and Subcommittee members, thank you for inviting me to submit a written statement for the hearing record on S. 2050, the High Risk Occupational Disease Notification and Prevention Act of 1986. My name is Carolyn Needleman. I hold a doctoral degree in sociology, and am currently a social work educator on the faculty of Bryn Mawr College, where I head the Doctoral Program in the college's Graduate School of Social Work and Social Research. I also direct Bryn Mawr College's doctoral social work concentration in Occupational and Environmental Health, a program designed to train professional social workers for advanced practice and program development related to the treatment, compensation and prevention of occupational and environmental disease. As director of this program, I have had professional experience with the design and evaluation of worker notification programs. I am also testifying on behalf of the National Association for Public Health Policy, a nonprofit organization founded in 1979 to develop and advocate public health policy.

I would like to start by expressing my strong support for S. 2050. Providing health warnings to individuals at high risk for occupational disease is an excellent preventive medicine and public health measure, which -- as the sponsors of this legislation point out -- will save both lives and money. It is also, as they note, a matter of simple justice. In a democracy such as the United States, the government has a moral responsibility to disclose data about health hazards to those known to be at risk. Workers have a right to this information so that they can make informed decisions, individually and collectively, about their own best interests -- legal, political, and social as well as medical.

My remarks will be brief, since I have testified at length in hearings held last November on a closely comparable House bill, H.R. 1309. The Senate bill, having had the advantage of review and comment related to the earlier House bill, has incorporated a number of modifications that are definitely improvements and should be retained in any reconciliation of the two versions. In my opinion, S. 2050 is quite a sophisticated legislative proposal, which anticipates and provides for many of the possible adverse effects of notification that might be expected on the basis of past experience.

My expertise is in the area of the social impact of risk notification and how notification programs can best meet the needs of workers and their families, so I will concentrate on those issues -- particularly since the legal, scientific and

economic aspects of this proposed legislation have been addressed by other witnesses. While in general the bill seems quite sensitive and well thought out in terms of its social aspects, there are still some concerns you may want to consider in your further deliberations. These concerns might call for attention in the implementation process or through companion legislation rather than in this bill directly, but you will want to be sure that the language of S. 2050 does not prevent appropriate action later.

Preventing Misunderstanding by Non Notified Workers

Adoption of a single definition of populations at risk, rather than multiple risk categories, is a distinct improvement. The single category approach is better suited to the realities of scientific uncertainty in making risk estimates, will eliminate delays involved in unnecessarily refined risk determinations, and will be much easier for notified individuals to deal with psychologically. One possible negative result of a dichotomous rather than graded evaluation of risk, however, is that workers who are NOT notified may construe the distinction as "at risk" versus "safe," rather than thinking of it in terms of degrees of risk. That is, they may erroneously conclude that they were not notified because their job hazards have been evaluated and found to be completely safe. Interviews with occupational disease victims suggest that this kind of faith in regulation is fairly common among workers, despite a surface cynicism. Particularly where a union is not present to provide worker education and social support, people tend to overrate the protection that health and safety regulation affords them, and to assume that someone in authority would tell them if their working conditions were really hazardous.

This potential misinterpretation by workers (and perhaps their employers as well) could be a real problem. The risk determinations described in S. 2050 will necessarily reflect average risk to large populations of workers in certain occupational categories, rather than actual risk to individual workers. Workers who have individually high exposure in a generally low risk occupation will not receive letters. Specific worksites or specific tasks involving particularly high exposures may get "washed out" statistically if the occupational categories used in determining risk levels are defined broadly rather than narrowly. It seems almost inevitable that some workers who do not receive notification letters will actually be at high risk as individuals.

In terms of a solution to this problem, I'd suggest three

things. First, in addition to the risk determination approach outlined in Section 4, notification letters should go out to all individual workers known to be at high risk from data presently held by NIOSH, OSHA or EPA. If this kind of individual notification is already being done, the agencies in question should have no objection to incorporating language reinforcing the requirement into this bill. If it's not being done, it needs to be made mandatory. Logically, the release of information about individual workers already known to be at risk should be the first wave of notification under this bill, to be undertaken immediately while the broader risk determinations are being made. Second, it would seem useful to include a brief (one sentence) explanation in the notification letters and any accompanying publicity, to the effect that NOT being notified does not necessarily mean one's working conditions are safe. Workers are going to talk to each other and their friends and families about these letters and will be each other's most immediate source of information, so the notification letters are probably the best way to reach those who are NOT being notified as well as those who are. Third, besides preventing the misunderstanding that non-notification equals safety, the notification letter should advise workers who feel they may be individually at risk -- whether notified or not -- to consult their union, their employers, OSHA, a local COSH group, or the bill's hot line. Given that the goal of this effort is to prevent disease and save lives, why not get the most mileage possible out of these letters, by using them to spread information about how any worker, notified or not, can get help with health and safety concerns? In previous testimony I argued myself that the letters should not be overly long and involved, but we are talking here about one or two sentences, with a large potential multiplier effect in terms of health results.

Building Social Workers into the Notification Effort

I am very pleased to see the strong emphasis on social services in S. 2050. I believe such services to be absolutely critical to the program's effectiveness, in terms of getting those notified to respond with constructive, health protecting actions and with a minimum of negative psychological and social effects. I think that's a conclusion most professionals with field experience in risk notification would support.

There is a danger, however, with the present language of the bill, that the apparent commitment to social services might not get realized. Inclusion of social service professionals into this kind of a program isn't something that will just happen. It has to be carefully planned, because it's a break with past

traditions of viewing occupational health and safety as primarily a medical and technical problem.

One problem is that the link between the federal occupational health and safety establishment and the core social service profession of social work is still very new and rather fragile. NIOSH funds have not been used to train social workers as occupational health professionals. OSHA New Directions programs have not made much use of social workers. The ERC's don't have well developed resources related to social services, either in terms of service delivery or training of social service professionals. Very, very few of the occupational health clinics that might become certified as state centers under this bill's Section 6 will be able to meet the social service requirements of 6(a)(2) and 6(b), without major addition of staff. The supply of social workers specifically trained in occupational health is too small at present to meet the implied demands of the bill.

The problem is underscored by the fact that even in this bill itself, for all its sensitivity to social services, social workers are sometimes conspicuously absent where they should be specifically mentioned. For instance, given the heavy emphasis on social services elsewhere in the bill, shouldn't a social service professional appear somewhere in Section 4(a)(1), in the list of professions eligible to serve on the risk assessment board? An appropriately trained social worker would be extremely useful on that board, contributing skills and perspectives that are badly needed in a practical sense. Yet the bill's present language will in effect prevent this kind of expertise from being represented.

That's one specific spot where I feel a wording change would be helpful. Unfortunately, most of the difficulties I foresee in getting the social service aspects of this bill developed are harder to fix. They are more a matter of changing traditional ways of thinking about how federal occupational health programs should be implemented, and what kinds of professional expertise are appropriate and necessary. For years, the standard list of "occupational health professions" has been limited to those listed in Section 4(a)(1) -- epidemiology, toxicology, industrial hygiene, medicine and nursing. Social workers simply haven't been part of the picture. Now that the need for occupational health social services is becoming apparent, the first impulse is to turn to familiar professional categories (for instance, occupational health nurses), rather than making a new linkage to professionals specifically trained for delivering social services. That's obviously illogical. It would be much better if the involvement of professional social work in occupational health could be developed in a planned

fashion, to take advantage of this already existing pool of expertise.

Outside of making social workers eligible to serve on the Risk Assessment Board and adding "by qualified social service professionals" here and there in this bill, I don't think S.2050 can get at this problem directly. I just wanted to explain a continuing problem in occupational health program development, which may undercut legislative initiatives such as this one. My hope is that members of this committee may be able to find ways of encouraging more federal attention to social work as an occupational health profession.

Two Telephone Hot Lines, Differently Staffed

When the hot line was designed for physicians only, as in the House bill, it was all right for it to "provide additional medical and scientific information concerning the nature of the risk and its associated disease," with the unspoken assumption that it would be staffed by health professionals. But now the hot line has been redefined in the Senate bill as an information service for the notified workers as well. This is an excellent change, one I argued for in previous testimony, and I'm very glad to see it. But unfortunately the hot line's purpose has not been redefined to match, and the result is going to be a very inappropriate service if the language remains as it is in Section 5(d). For worker information, the hot line should not be seen simply as a neutral vehicle for transferring health information. Workers who call in are going to be upset and uncertain about what course of action to take, and the quality of the phone contact will very likely be a critical factor in determining whether they panic, ignore the notification, or take some constructive action. This fact makes the worker information hot line in some ways the single most important program element in the whole notification effort. It needs to be done right. Merging it in with a cool, dispassionate, technically oriented physicians' information service is the wrong approach.

I strongly advise that the two hot line purposes be separated, with different numbers and with different kinds of staffing. The primary purpose of the hot line for workers is not so much to give medical information or even long distance health counseling, but rather to get the callers motivated to contact appropriate professionals in their own communities, for personalized diagnosis and ongoing health care. What's needed for the worker information hot line is a very sophisticated staff professionally trained in telephone crisis intervention, in responding to irrational or poorly articulated concerns, and in

dealing with fragile motivation to seek needed help. These are core skills in social work practice, for which professional social workers receive years of graduate training. But unless social workers (or at least "qualified social service professionals") are specifically written into Section 5(d), the hot line staffing will almost certainly be drawn from the same old familiar list of five health/technical professions that everyone is used to dealing with in occupational health. As explained above, if the intent of the bill is to build in social services in a meaningful way, the idea that this means including some social workers needs to be made very explicit.

Added Protection for Notified Workers' Job Security

In general the bill is well constructed to protect workers from job discrimination related to notification, but there are two areas where I think it should be strengthened.

One is the issue of confidentiality. Some language should be added to limit access to the notification lists of individual workers; Section 4(b)(3) might be an appropriate place for a sentence to that effect.

The other issue has to do with the prohibitions and sanctions for discrimination as stated in Section 8. My concern is not with this section per se, but with how to make it more affirmative in its effect, so that discrimination can be prevented rather than punished after the fact. Section 5(c)(4)(D) proposes using the notification letter itself to explain these protections to the worker, which is a good addition and should be kept. But this is still a little too indirect, since it leaves it up to the notified workers to transfer the information to their employers. For those in unorganized workplaces and those who feel vulnerable for other reasons, this approach may not be effective. Since it's the employer's and the insurer's actions that are the target, why not add a provision to inform affected employers and insurers directly that discrimination related to notification is illegal? This could be done as a general warning without disclosing individual names of notified workers. If using letters for this purpose seems infeasible, maybe it could be done through some other form of publicity. It just seems more realistic for the news to reach potential discriminators directly from the government, rather than indirectly from the potential victims of discrimination.

In general, I feel that S. 2050 meets an urgent social need in an extremely sophisticated, responsible, and cost effective way. I expect it to become an important landmark in occupational health legislation, and I appreciate having this opportunity to comment on the bill.

Senator NICKLES. We will keep the record open for another 3 or 4 weeks for your opportunity to respond to any questions from members of the committee.

Thank you very much.

[Whereupon, at 12:05 p.m., the subcommittee was adjourned.]

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